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IN THE

Supreme Court of the United States

OCTOBER TERM, 1993

ADMINISTRATORS OF THE TULANE EDUCATIONAL FUND
d/b/a TULANE MEDICAL CENTER HOSPITAL
AND CLINIC, *et al.*,

Petitioners,

v.

DONNA E. SHALALA, Secretary,
Department of Health and Human Services,

Respondent.

Petition For A Writ Of Certiorari
To The United States Court Of Appeals
For The District Of Columbia Circuit

PETITION FOR A WRIT OF CERTIORARI

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September 28, 1993

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QUESTION PRESENTED

Whether 42 U.S.C. § 1395ww(h) (2) (A), which provides that a hospital's Medicare reimbursement for graduate medical education ("GME") costs for years beginning on or after July 1, 1985, shall be based in substantial part upon the amount of the hospital's GME costs "recognized as reasonable under this subchapter" for fiscal year 1984, authorizes the Secretary of Health and Human Services to reaudit fiscal year 1984 and redetermine the amount of such costs long after the initial audits for that year had become final and binding by regulation.

PARTIES TO THE PROCEEDINGS

The six petitioners here are the same parties as the six plaintiffs before the district court and the six appellees before the court of appeals. They are: The Administrators of the Tulane Educational Fund d/b/a Tulane Medical Center Hospital and Clinic, Methodist Hospitals of Memphis, George Washington University Hospital, Lucy Webb Hayes National Training School for Deaconesses and Missionaries d/b/a Sibley Memorial Hospital, Greater Southeast Community Hospital, and Fairfax Hospital. The parent of Methodist Hospitals of Memphis is Methodist Health Systems. The parent of Fairfax Hospital is Inova Health Systems. Greater Southeast Community Hospital has the following parents and subsidiaries: Greater Southeast Asset Management Company, Greater Southeast Community Hospital Foundation, Ft. Washington Community Hospital, Inc., and Ft. Washington Medical Center, Inc.

The respondent is Donna E. Shalala, Secretary of the Department of Health and Human Services.

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OPINIONS BELOW

The opinion of the court of appeals (App. at 1a-17a) is reported at 987 F.2d 790. The opinion of the district court (App. at 18a-42a) is reported at 799 F. Supp. 1210.

JURISDICTION

The judgment of the court below was entered on March 9, 1993. Rehearing was denied on June 30, 1993. The

jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

The key statutory provision at issue is 42 U.S.C. § 1395ww(h)(2)(A). So that the Court may review that provision in context, substantial portions of 42 U.S.C. § 1395ww(h) are reproduced in the Appendix at 46a-51a.

In addition, relevant portions of the following statutory and regulatory provisions are reproduced in the Appendix at 51a-55a: 42 U.S.C. § 1395oo(a); 42 U.S.C. § 1395ww(a)(1)(C); 42 U.S.C. § 1395ww(b)(3)(A); 42 C.F.R. § 405.481(g); 42 C.F.R. § 405.1803(a); 42 C.F.R. § 405.1807; 42 C.F.R. § 405.1885(a); and 42 C.F.R. § 413.86(e)(1).

STATEMENT

Petitioners challenge the validity of a 1989 Medicare regulation (the reaudit regulation) which directed the Secretary's agents to reopen and reaudit *closed* 1984 cost reports (for which hospitals were no longer required to have supporting audit documentation) to establish 1984 graduate medical education ("GME") costs for purposes of the Medicare GME payment methodology applicable to cost reporting years beginning in 1985. This regulation has resulted in the Medicare program using a different determination of 1984 GME costs for purposes of the 1985 payment methodology than the "final and binding" determination of GME costs made to reimburse hospitals for 1984 itself.

The district court invalidated the reaudit regulation as inconsistent with the governing Medicare statute and violative of applicable prohibitions against retroactive rulemaking, in contravention of this Court's decision in *Bowen v. Georgetown University Hospital*, 488 U.S. 204 (1988). The court of appeals reversed. Further review is war-

ranted because (1) the issue is one of enormous national importance affecting literally hundreds of hospitals throughout the country; (2) the question of the Secretary's authority to reaudit *closed* base years should be definitively resolved before scores of man-years are devoted to litigating hundreds of individual cases involving the merits of the 1984 reaudit adjustments, particularly given the enormous due process difficulties that litigation in the mid- to late nineties (and beyond) involving *closed* 1984 cost reporting years would necessarily entail; and (3) the court of appeals' decision conflicts with this Court's decision in *Georgetown*.

A. ***Medicare Reasonable Cost Reimbursement***. In 1965, Congress enacted the Medicare program primarily to furnish health insurance for the elderly. Pub. L. No. 89-97, § 102(a). From that time until 1983, the Medicare program reimbursed participating hospitals the "reasonable cost" incurred in furnishing services to Medicare patients. *Good Samaritan Hospital v. Shalala*, 113 S. Ct. 2151, 2154 (1993).[1]

Effective with cost reporting years beginning on or after October 1, 1983, Congress adopted a prospective payment system ("PPS") to reimburse most hospitals for inpatient *operating* costs. Pub. L. No. 98-21, § 601(e), enacting 42 U.S.C. § 1395ww(d). However, Congress retained the "reasonable cost" reimbursement system for certain hospital costs, including the costs of medical education. 42 U.S.C. § 1395ww(a)(4).

B. ***The Medicare Claims and Appeals Process***. The Secretary has contracted Medicare audit and payment functions to organizations (usually insurance companies) known as fiscal intermediaries. 42 U.S.C. § 1395h; *Bethesda Hospital Association v. Bowen*, 485 U.S. 399, 400-

[1] The only exception was if a hospital's costs exceeded its prevailing charges, in which case it was reimbursed its charges. 42 U.S.C. § 1395f(b)(1).

01 (1988). At the close of a year, a Medicare provider files a cost report with its Medicare intermediary, which audits the cost report and issues a determination of the costs recognized as reasonable in a notice of program reimbursement ("NPR"). 42 U.S.C. § 1395oo(a)(1)(A)(i); 42 C.F.R. § 405.1803(a)(1); *Bethesda Hospital Association*, 485 U.S. at 401. A provider dissatisfied with the intermediary's determination may appeal to the Provider Reimbursement Review Board ("PRRB" or "Board") and eventually file a court suit. 42 U.S.C. § 1395oo(f)(1).

The intermediary's "findings on matters at issue" in the NPR are subject to reopening for a period of three years. 42 C.F.R. § 405.1885(a). Except in cases of fraud, no intermediary determination "may be reopened after such 3-year period." *Id.* If the provider does not appeal and a reopening has not been effected within the three-year period, the intermediary's determination is "final and binding." 42 C.F.R. § 405.1807.

C. ***The GME Per Resident Amount Payment Methodology***. In 1985, the Secretary issued a regulation which effectively froze medical education payments for one year. Under the Secretary's regulation, a hospital's medical education reimbursement for its first cost reporting year beginning on or after July 1, 1985, would be the lower of its allowable medical education costs for that year or for its cost reporting year beginning in fiscal year 1984 (the base year). 42 C.F.R. § 405.421(a)(2)(i) (1985); 50 Fed. Reg. 27,732 (1985). In the accompanying preamble, the Secretary made clear that the final determination of allowable base year costs for the base year itself would also be used for purposes of the freeze. 50 Fed. Reg. 27,726 (1985).

In 1986, Congress repealed the Secretary's freeze, but adopted a new GME payment methodology (effective for cost reporting years beginning on or after July 1, 1985), based, like the Secretary's regulation, on a hospital's GME costs during fiscal year 1984. Pub. L. No. 99-272, § 9202. The statute directed the Secretary to calculate an "av-

erage" for each hospital. 42 U.S.C. § 1395ww(h)(2)(A). This was to be done by dividing the hospital's GME costs "recognized as reasonable under this subchapter" for 1984 by the hospital's number of interns and residents in 1984, to yield an "average" base year amount per resident. *Id.* Payment for a subject year is made by adjusting this amount for inflation and multiplying the adjusted amount by a hospital's current number of residents. 42 U.S.C. § 1395ww(h).

D. ***The Reaudit Regulation***. On September 29, 1989, the Secretary issued regulations to implement the GME statute. 54 Fed. Reg. 40,286-321, adopting 42 C.F.R. § 413.86. By that date, the Medicare intermediaries had already audited, and issued NPRs for, the 1984 year to be used as the GME base year for virtually all hospitals in the country. In most cases, an NPR had been issued for 1984 more than three years previously, which meant that the year was no longer subject to reopening. *See* 42 C.F.R. § 405.1885(a). In addition, by that date hospitals were no longer required to retain the time records essential for an audit of GME costs. 42 C.F.R. § 405.481(g)(3).

Nonetheless, the Secretary did not instruct the intermediaries to use the 1984 GME costs established in the normal NPR process to determine the "average" GME per resident amount. Instead, the Secretary issued the reaudit regulation, which directed the intermediaries to reaudit a hospital's 1984 year to establish the 1984 GME costs to be used for the GME per resident amount calculation. 42 C.F.R. § 413.86(e)(1)(ii)-(iii). The Secretary asserted that a reaudit of 1984 costs was necessary to ensure the accuracy of the per resident amount. 54 Fed. Reg. 40,300 (1989).

As a practical matter, a reaudit of 1984 costs often proved to be impossible. Under the Secretary's record retention requirements (42 C.F.R. § 405.481(g)(3)), hospitals were required to retain physician allocation agreements and time records only for a period of four years after the

close of a cost reporting year.[2] The four-year record retention period had already expired when the Secretary issued the reaudit regulation, and many hospitals no longer had the necessary records. Thus, the Secretary found it necessary to issue a *Federal Register* notice acknowledging the problem of non-existent records stemming from expiration of the four-year record retention period. 55 Fed.Reg. 36,063-64 (1990). In these instances, the Secretary authorized the intermediaries to reaudit a year subsequent to the 1984 year specified in the statute. *Id.* The intermediaries were directed to use the physician allocation percentage derived from the audit of the later year unless it was higher than the percentage recognized in the NPR for 1984, in which case the intermediaries were to use the 1984 physician allocation percentage. *Id.*

E. ***Intermediary Reaudits of Petitioners***. The pertinent facts are identical in principle for all six petitioner hospitals. For simplicity, the facts applicable to Methodist Hospitals of Memphis ("Methodist"), the lead plaintiff before the district court, will be recited here.

Methodist's GME base year is its cost reporting year ending December 31, 1984. Joint Appendix ("J.A.") at 110.[3] After auditing the 1984 year, Methodist's intermediary issued an NPR on February 28, 1986. *Id.* at 102-103A.

Three years passed after issuance of the NPR for Methodist's 1984 cost reporting year without a reopening related to medical education costs. *Id.* at 99, ¶ 4. Accordingly, as of March 1, 1989 (three years and one day after issuance of the NPR), the intermediary's determination was

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[2] Physician compensation attributable to teaching activities is a major component of GME costs. 42 C.F.R. §§ 405.480-405.481. Hospitals are required to conduct time studies to establish for each year the percentage of a physician's compensation attributable to various activities, including teaching. 42 C.F.R. § 405.481(g).

[3] The "Joint Appendix" was filed with the court of appeals on October 15, 1992.

"final and binding" and no longer subject to reopening. 42 C.F.R. §§ 405.1807, 405.1885(a). Moreover, as of January 1, 1989 (four years and one day after the close of its GME base year), Methodist was no longer even required to retain the physician allocation documentation supporting the GME costs found to be allowable in the NPR for 1984. *See* 42 C.F.R. § 405.481(g)(3).

Methodist's Medicare intermediary nonetheless began reauditing the hospital's 1984 year in late 1990 for purposes of the GME per resident amount methodology. On February 26, 1991, it issued a notice of average per resident amount for the hospital's 1984 year. J.A. at 112-113. The amount of 1984 GME costs allowed in that notice was lower than the amount recognized as reasonable in the 1986 NPR for 1984. J.A. at 100, ¶¶ 5-7. The Medicare intermediary is using the 1991 reaudit determination of 1984 GME costs to reimburse Methodist for all cost reporting years beginning on or after July 1, 1985.

F. ***PRRB Proceedings***. Methodist timely appealed the intermediary's notice of average per resident amount to the PRRB. J.A. at 110-111. Methodist challenged the legality of the Secretary's reaudit regulation, contending that the intermediary must use the amount actually recognized as reasonable for 1984 (rather than the reaudit amount) to establish the base year per resident amount under the new methodology. *Id.* Methodist also appealed each of the intermediary's reaudit adjustments on the merits. J.A. at 111. Utilizing a process known as "expedited judicial review," Methodist exhausted administrative procedures with respect to its challenge to the validity of the reaudit regulation and timely filed a court suit.[4] *See* 42 U.S.C. § 1395oo(f); App. at 26a-33a.

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[4] The merits of the specific reaudit adjustments remain before the PRRB, which has recently stayed proceedings pending this Court's resolution of this case.

G. ***District Court Decision***. On July 17, 1992, the district court (per Judge John Pratt) invalidated the Secretary's reaudit regulation. App. at 18a-42a. The court held that the reaudit regulation "violates the plain meaning of the statute," which requires the Secretary to use the amount "recognized as reasonable under this subchapter" for 1984 to establish the base year per resident amount. *Id.* at 34a. It stated that the Secretary may not use "two different 'base-year' amounts" and that the amount "derived from the standard cost reporting and review process" to reimburse hospitals for 1984 must also be used to compute their base year per resident amount under the new methodology. *Id.* at 36a.

The court also found that the reaudit regulation is an impermissible retroactive rule. *Id.* at 38a-40a. It noted that several provisions in the statute authorize retroactive rule making with respect to specific components of the new methodology, but none authorized a reaudit of 1984 costs. *Id.* at 39a-40a. It concluded that the express delegation of retroactive rulemaking authority required by this Court's decision in *Bowen v. Georgetown University Hospital* was absent. *Id.* at 38a-40a.

H. ***Court of Appeals Decision***. On March 9, 1993, the court of appeals reversed. App. at 1a-17a. The court stated that the statute was ambiguous as to whether Congress intended the Secretary to use the 1984 GME cost figure established through the normal NPR and reopening process or whether it intended to allow the Secretary to establish a new 1984 GME cost figure for the per resident amount methodology. *Id.* at 11a-12a. It concluded that the Secretary's resolution of this ambiguity was justified to ensure the accuracy of the GME per resident amount. *Id.* at 13a-14a.

The court also found that the reaudit regulation is not a retroactive rule. *Id.* at 15a-17a. It characterized the rule

as applying only to "future reimbursements" and as adding no retroactivity not inherent in the statute itself. *Id.*

REASONS FOR GRANTING THE PETITION

A. ***Importance of Case***. This case presents a question of immense importance for the nation's teaching hospitals. At issue is the Secretary's authority to reaudit in 1991 *closed* 1984 cost reporting years for purposes of applying a 1985 Medicare payment methodology. Because of the importance of resolving this issue quickly, both the district court and court of appeals proceedings were expedited. As the Secretary noted in a court of appeals filing, the parties' stipulation to expedited proceedings "reflects the parties' awareness that the issues presented by these cases should be resolved as quickly as possible, because they involve millions of dollars in Medicare reimbursements and affect many Medicare hospitals across the country." Secretary's filing of September 8, 1992 at 3.

A definitive resolution of this issue is needed as soon as possible to avoid the possibility that scores of man-years will be wasted litigating the merits of adjustments that the Secretary lacked the authority to make. Over 500 hospitals have filed appeals with the PRRB challenging the Secretary's reaudit adjustments. Letter dated August 30, 1993, from Melodye L. Hardy, Freedom of Information Officer, to Christopher Keough.[5] The PRRB will hear the first of these cases later this year and many more in 1994, and many of the cases will eventually make their way into federal district courts around the country. *See* 42 U.S.C. § 1395oo(f)(1). These are very complicated cases which will

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[5] Petitioners filed a Freedom of Information Act request for a list of all cases pending before the PRRB contesting the Secretary's base year per resident amount determinations. The Secretary's response listed a total of 504 cases. Since several of the cases were filed as group appeals under 42 U.S.C. § 1395oo(b), the total number of participating hospitals undoubtedly significantly exceeds 504.

require an enormous expenditure of time and resources by the PRRB, the federal courts, the nation's teaching hospitals, the Medicare intermediaries, and the Secretary. Virtually all of this effort will be unnecessary if it is ultimately determined that the Secretary lacked the authority to conduct reaudits of *closed* 1984 years, as petitioners contend.

The court of appeals decision has not definitively resolved the issue of the Secretary's reaudit authority. Other hospitals may, after exhausting administrative procedures, file suit in the federal district court for the judicial district in which they are located to litigate both the merits of the reaudit adjustments and the question of the Secretary's reaudit authority. 42 U.S.C. § 1395oo(f)(1). Thus, were the Court to deny review of this case, eventually there would be numerous district court cases, filed in every judicial circuit, that raised, among other things, the issue of the Secretary's authority to reaudit 1984 costs for closed 1984 years. The strength of petitioners' arguments (discussed below) is such that a conflict between the circuits on this issue would be inevitable. However, by the time a conflict would develop with respect to the issue of the Secretary's reaudit authority, enormous public and private resources would have been expended litigating the merits of the specific reaudit adjustments. A decision issued by this Court in 1994 resolving the issue of the Secretary's reaudit authority could save the wasteful expenditure of enormous resources; a decision issued in the year 2000 would be too late since many resources would already be expended. Thus, there is an urgent need to definitively resolve the fundamental question of the Secretary's authority to reaudit 1984 costs before the merits of the specific 1984 reaudit adjustments are litigated in hundreds of PRRB and court cases across the nation.

The need is made even greater because of the enormous difficulties that litigation of the merits of the adjustments will entail. Under the best of circumstances, litigating adjustments for 1984 in the mid- to late nineties and on into

the next century would be difficult. However, the difficulty is greatly exacerbated by the fact that the adjustments were made after the 1984 year was closed and after hospitals were free to discard audit documentation. As discussed below, the reaudit regulation retroactively upset settled expectations of finality based on the Secretary's reopening standards and principles of res judicata. The problems of proof in such litigation are daunting. The due process and fairness issues that will arise in such litigation are apparent.

Finally, the court of appeals decision conflicts with this Court's decision in *Bowen v. Georgetown University Hospital*. The reaudit regulation is clearly retroactive. The Secretary is using it to recoup Medicare payments for the period 1985-1989, which preceded issuance of the rule. Moreover, the rule modified Medicare reopening standards *after* the 1984 cost determinations were final and binding under those standards. The court of appeals upheld the validity of this retroactive rule even though the "express" grant of retroactive rulemaking authority required by *Georgetown* was absent. Accordingly, further review is warranted.

B. ***Plain Meaning of Medicare Statute***. 42 U.S.C. § 1395ww(h) prescribes several steps for computing a hospital's payment rate under the GME per resident amount methodology. This case involves the first step. The relevant paragraph provides:

> DETERMINING ALLOWABLE AVERAGE COST PER FTE RESIDENT IN A HOSPITAL'S BASE PERIOD.—The Secretary shall determine, for the hospital's cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this subchapter for direct graduate medical education costs of the hospital for each full-time-equivalent resident.

42 U.S.C. § 1395ww(h)(2)(A).

The statute directs the Secretary to determine an "average." She does this by dividing (A) the "amount recognized as reasonable under this subchapter" for a hospital's 1984 cost reporting year by (B) the hospital's number of full-time-equivalent residents for that period. At issue is the meaning of (A)—the numerator. The district court held that the statutory language clearly means the final amount determined as reasonable for 1984 through the normal audit and review process. The court of appeals found these words ambiguous, thus enabling the Secretary to establish a separate 1984 cost determination for the per resident amount methodology that differs from the final determination made for 1984 itself. The court of appeals is wrong for several reasons.

1. ***Single Determination of Costs Under Statute***. The statute refers to the "amount recognized as reasonable *under this subchapter*." (Emphasis added.) The court of appeals overlooked the underscored language. To properly construe these words, one must ask: What processes does "this subchapter" (subchapter XVIII of the Social Security Act) establish for determining the amount recognized as reasonable for a particular year? If the "subchapter" establishes more than one such process, the statutory reference may be ambiguous. But if the "subchapter" establishes only one such process, the statutory reference is quite clear.

In fact, subchapter XVIII establishes only one process for determining the amount recognized as reasonable for each year. 42 U.S.C. § 1395oo(a) directs the Medicare intermediary to make a "final determination" as to each hospital's payment entitlement for each cost reporting year. A hospital dissatisfied with that determination has 180 days to appeal to the PRRB. 42 U.S.C. § 1395oo(f)(1). Moreover, the intermediary may reopen the determination within a three-year period. 42 C.F.R. § 405.1885(a). Once

that period expires, the determination is "final and binding." 42 C.F.R. § 405.1807.

Subchapter XVIII thus provides a process by which a single "final and binding" payment amount is established for each year. Since there is only one such amount, Congress' reference in the GME statute to the "amount recognized as reasonable under this subchapter" for the base year is obviously to this amount—as the district court found.

2. ***Absence of Statutory Authorization***. Throughout the GME legislation, Congress was careful to confer express authority on the Secretary where rulemaking was required. For instance, the number of a hospital's interns and residents (the denominator in the per resident amount formula) had no bearing on GME reimbursement for 1984, and the Secretary did not have a methodology for establishing the number for purposes of the GME payment. Accordingly, Congress expressly authorized the Secretary to establish rules "for the computation of the number of full-time-equivalent residents in an approved medical residency training program" and furnished copious guidance. 42 U.S.C. § 1395ww(h)(4).

No such rulemaking authorization will be found with respect to the numerator. None was needed. The Medicare statute and regulations long ago established a process by which the Secretary determines the amount of GME costs recognized as reasonable for each cost reporting year.[6] If Congress had intended for the Secretary to bypass that process and create a new process, it surely would have conferred some rulemaking authority on the Secretary, as

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[6] Congress used the past tense ("recognized") not because the final 1984 amount had been established at the time of the statute's enactment, but because 1984 preceded the years subject to payment under the GME methodology. Accordingly, a final determination of the amount recognized as reasonable for 1984 would necessarily be made before final payments were due for the subsequent years.

it had done with respect to the denominator in the equation. It did not do so.

The court of appeals' suggestion that "determine" is itself an "activist" word that might be construed to authorize a reaudit does not bear analysis. App. at 12a n.6. For purposes of establishing an "average," "determine" is no more "activist" than "compute" or "calculate." *Directing the Secretary to "determine" an "average" by dividing (A) by (B) does not authorize the Secretary to "redetermine" (A).* For instance, if Congress were to direct the Secretary to "determine" the "average" number of runs scored per game in the 1984 World Series, it obviously would not be authorizing the Secretary to order the 1984 World Series to be replayed in 1991. The Secretary's reaudit regulation represents no less drastic a departure from the clear wording of the statute than this example.

The district court quite properly noted that if Congress had intended a redetermination of allowable base year costs, it could easily have conveyed its intent. App. at 36a. If the Secretary's construction were correct, the statute would say something like this:

> The Secretary shall redetermine, for purposes of this section, the amount of the hospital's allowable direct graduate medical education costs for the hospital's cost reporting period that began during fiscal year 1984, and, based on that redetermined amount, the Secretary shall determine the hospital's average amount of allowable direct graduate medical education costs for each full-time-equivalent resident for such year.

Instead, the statute directs the Secretary to use as the numerator the "amount" of a hospital's GME costs "recognized as reasonable under this subchapter" for 1984.

3. ***Inconsistent Construction of Identical Words.*** A review of the broader context in which the statute was

enacted clearly supports the district court's "plain meaning" construction. Congress borrowed the notion of basing reimbursement for future years on the GME costs recognized for 1984 from the regulation which the Secretary issued in 1985, which would have frozen GME costs at 1984 levels. 42 C.F.R. § 405.421(a)(2)(i) (1985). In the preamble accompanying promulgation of that regulation, the Secretary made clear that the final determination of 1984 costs established for 1984 would also be used as the 1984 amount for purposes of the freeze:

> If an appeal of base year costs is resolved in favor of a provider, we would increase the allowable base year costs for the purpose of applying the limit. Similarly, if the base year costs are reduced, the allowable direct medical education costs for the limit year would be decreased.

50 Fed. Reg. 27,726 (1985).

Moreover, the basic concept in section 1395ww(h)(2)(A) parallels other provisions of section 1395ww enacted just a few years earlier. For instance, in 1982, Congress enacted two limits applicable to cost reimbursement. For one of these, Congress specified that the limit "shall in no event be lower than the allowable operating costs of inpatient hospital services . . . *recognized under this subchapter* for such hospital for such hospital's [base year]." 42 U.S.C. § 1395ww(a)(1)(C) (emphasis added). The other limit (denoted the "target amount") was defined in terms of "the allowable operating costs of inpatient hospital services . . . *recognized under this subchapter* for such hospital for [the base year]." 42 U.S.C. § 1395ww(b)(3)(A)(i) (emphasis added). In neither case has the Secretary conducted a reaudit to determine the amount of the limit. In both cases, the Secretary has used the final determination of allowable costs established under the normal administrative

review process for the base year itself in determining the amount of the limit.

In 1983, Congress incorporated the "target amount" into the prospective payment system ("PPS") for operating costs, again using a hospital's allowable operating costs "recognized under this subchapter" for a base year (the "hospital-specific rate") to determine future reimbursement. 42 U.S.C. §§ 1395ww(d)(1)(A)(i)(I), (ii)(I), incorporating 42 U.S.C. § 1395ww(b)(3)(A). The Secretary did not reaudit the base year costs to be used for future years, but she issued a regulation that permitted the use of two different base year amounts in limited circumstances.[7] The court of appeals invalidated that regulation in *Georgetown University Hospital v. Bowen*, 862 F.2d 323 (D.C. Cir. 1988) ("*Georgetown II*"). Quoting the district court opinion, the court of appeals held:

> "A final administrative or judicial decision . . . that a particular cost was, indeed, 'allowable' in the base year should provide *conclusive proof* that the cost should be included in the provider's [hospital specific amount] for the PPS year under appeal." *Georgetown Univ. Hospital v. Bowen*, 698 F. Supp. 290, 296 (D.D.C. 1987).

862 F.2d at 327 (emphasis added; brackets supplied by court of appeals).[8] The Secretary subsequently issued a

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[7] The Secretary used the base year NPR to establish the PPS hospital-specific rate, but in most instances she declined to adjust the hospital-specific rate to reflect subsequent adjustments to the NPR resulting from reopenings, administrative decisions, and judicial decisions applicable to the base year.

[8] In *Tulane*, the court of appeals distinguished *Georgetown II* on the ground that *Georgetown II* involved a regulation that sometimes cemented erroneous determinations. App. at 11a. However, the *Tulane* court failed to recognize that, by accepting the binding effect of a "final" administrative or judicial decision for the base year, the *Georgetown II* holding also had the effect of sometimes cementing erroneous

nationwide acquiescence in the court decision. *See* Health Care Financing Administration Ruling 89-1, [1989 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 37,614 (1989).

In other provisions of section 1395ww, statutory references to amounts "recognized under this subchapter" for base years have been consistently construed to mean the amounts actually recognized in the final determinations for the base years themselves. Only in this instance has there been a reaudit to establish a new base year amount to be used for subsequent years. The Secretary's regulation conflicts with the "normal rule of statutory construction," recently applied by this Court in the context of other subchapters of the Social Security Act, that "identical words used in different parts of the same act are intended to have the same meaning." *Sullivan v. Stroop*, 110 S. Ct. 2499, 2504 (1990), *quoting Sorenson v. Secretary of the Treasury*, 475 U.S. 851, 860 (1986).

4. ***Impossibility of Reauditing 1984 Costs***. The reaudit regulation often results in the 1984 GME per resident amount being based in substantial part on audit data from a year other than 1984. The Secretary recognized in 1990 that the record retention period for 1984 had already expired when the reaudit regulation was issued in 1989 and that hospitals were no longer required to have the physician time allocation data necessary for a reaudit of 1984 costs. 55 Fed. Reg. 36,063-64 (1990).[9] Therefore she au-

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determinations. Any "final" determination (whether it be for the PPS base year or the GME base year or any other cost reporting year) may be erroneous, but without finality all is chaos. The need to honor the finality of base year determinations is as compelling for the GME hospital-specific rate involved here as for the PPS hospital-specific rate in *Georgetown II*. There is no principled distinction.

[9] In the 1990 *Federal Register* notice, the Secretary acknowledged:

> [W]e now find that physician allocation agreements, time records and other information may no longer exist for the

thorized intermediaries to reaudit later years and use that data to establish the physician allocation percentage to be used for the 1984 GME per resident amount so long as that percentage does not exceed the percentage established in the final determination for 1984 itself. *Id.*

Congress expressly mandated that the per resident amount be based on cost reporting years beginning in fiscal year 1984. Thus, a regulation that necessitates auditing a year other than 1984 to establish the 1984 amount for the GME per resident amount methodology (as the reaudit regulation does) flatly conflicts with the governing statute.

C. ***Unreasonableness of Secretary's Construction***. As the foregoing demonstrates, the court of appeals erred in finding ambiguity in the statutory language. However, even assuming *arguendo* the existence of ambiguity, the court of appeals ignored the hard questions in assessing the reasonableness of the reaudit regulation. The reaudit regulation assumes that Congress intended to authorize the Secretary, without any express delegation of authority, to disregard established principles of finality and res judicata, to erect a cumbersome and unnecessary duplicative process to establish two separate amounts for the same year using the same principles of reimbursement, and to deprive hospitals of due process rights fundamental to any fair system of administrative law. These are serious matters that warrant immediate review before enormous efforts are spent litigating the merits of reaudit adjustments which, in petitioners' view and the district court's view, the Secretary lacked the authority to make.

> cost reporting period that began on or after October 1, 1983 but before October 1, 1984 (the base period) in establishing direct GME costs because the record retention requirements specified in [42 C.F.R.] § 405.481(g) only require the retention of each physician compensation allocation for four years after the end of each cost reporting period to which the allocation applies.

55 Fed. Reg. 36,063.

1. ***Reaudit Unnecessary for Accuracy***. The court of appeals' conclusion that a reaudit was necessary to ensure accuracy does not bear analysis. The original determination was an *audited* figure. There is no evidence in the record of inaccuracy in those determinations. The court of appeals simply accepted on faith the Secretary's conclusory allegations.[10]

But even more fundamentally, a "plain meaning" construction of the statute would not have prevented the Secretary from correcting any errors that might have existed.

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[10] By 1984, the Secretary's "reasonable cost" GME principles had been in effect for nearly twenty years, and the Medicare intermediaries had been conducting audits under those principles for nearly twenty years. Moreover, the Medicare intermediaries were able to devote their full attention to GME costs for the year serving as the GME base year. Since that year was also the first year under the new PPS for operating costs, the Medicare intermediaries were no longer required to audit operating costs (which account for approximately 80% of all hospital costs) under "reasonable cost" principles, thus allowing them much greater time than in the past to audit GME costs. *See, e.g.*, Comments of University of Michigan Medical Center at 4, *Methodist* docket entry 35, Exhibit 11. Indeed, they had special reason to be careful because, under the Secretary's 1985 regulation, their audit determination was to be used not only for 1984 reimbursement but also for the 1985 freeze.

The Secretary's assertion that per resident amounts varied from less than $10,000 to more than $100,000 in the base year audit proves nothing. The Secretary's reaudit determinations also resulted in the same variations. *See* court of appeals' filing of April 23, 1993, Exhibits 1 and 2. The variations in amounts are not surprising both because of the great variations in the sophistication and scope of GME programs and because of the particular methodology used by the Secretary to compute GME per resident amounts. A hospital's base year allowable costs (the numerator) included the costs which the hospital incurred in compensating its residents on rotation at other hospitals, but its intern and resident count (the denominator) included only the number of residents physically located on its premises. Thus, hospitals that transferred residents to other hospitals necessarily had a large per resident amount, while transferee hospitals had a relatively small per resident amount.

When the GME statute was enacted, the amount recognized as reasonable for 1984 was still subject to reopening. Thus, as the district court correctly observed, "[a]ny concern the Secretary might have had about the accuracy of those figures could have been addressed within the standard three-year period time." App. at 37a. Accordingly, the court of appeals' concern that the Secretary be allowed "elbow room for adjustments based on prior miscalculations or errors" was groundless. App. at 12a. A "plain meaning" construction of the GME statute allowed the Secretary three years of "elbow room."

2. ***Violation of Reopening Standards and Principles of Res Judicata***. The reopening standards apply "with respect to findings on matters at issue" in a determination. 42 C.F.R. § 405.1885(a). The "matters at issue" for which intermediaries made "findings" in the NPR issued for 1984 in 1986 were the allowability of a hospital's 1984 GME costs. Those were also the "matters at issue" for which intermediaries made new "findings" in the 1991 reaudits. Since those new "findings" of 1984 costs were made after the three-year reopening period had expired, they obviously conflicted with the Secretary's reopening standards. It matters not whether the Secretary applied those "findings" of 1984 costs directly to the 1984 year or to the 1985 year under the per resident amount methodology.

The reaudit regulation also conflicts with principles of res judicata and collateral estoppel. When an issue has been resolved for one year, principles of res judicata and collateral estoppel make that decision binding for subsequent years involving the same issue. *Tait v. Western Maryland Railway Co.*, 289 U.S. 620 (1933); *United States v. Moser*, 266 U.S. 236 (1924). Res judicata and collateral estoppel apply to final administrative determinations so long as there was "an adequate opportunity to litigate" the issue in the original determination, as there clearly was here. *United States v. Utah Construction & Mining Co.*, 384 U.S. 394, 422 (1966); *Draper v. Sullivan*, 899

F.2d 1127, 1130-31 (11th Cir. 1990).[11] It is irrational to assume, as the court of appeals did, that Congress intended the Secretary to retroactively revoke her own reopening standards and ignore settled principles of res judicata and collateral estoppel. Only the clearest and most direct statutory command could possibly justify such a result.

3. ***Reopening Standards Designed to Promote Accuracy***. Rationalizing the reaudits as necessary to ensure accuracy fails to take into account the purposes of a statute of limitations, of which the Medicare reopening standards are the functional equivalent. In *Board of Regents of the University of the State of New York v. Tomanio*, 446 U.S. 478, 487 (1980), this Court described those purposes as follows:

> Statutes of limitations are not simply technicalities. On the contrary, they have long been respected as fundamental to a well-ordered judicial system. . . . The process of discovery and trial . . . is obviously more reliable if the witness or testimony in question is relatively fresh. Thus in the judgment of most legislatures and courts, *there comes a point at which the delay of a plaintiff in asserting a claim is sufficiently likely either to impair the accuracy of the fact-finding process or to upset settled expectations that a substantive claim will be barred without respect to whether it is meritorious.*

(Emphasis added.) Elsewhere, the Court has stated:

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[11] This is even a stronger case for the application of res judicata than the cited court cases. Those cases involved a monetary entitlement for a later year based on the resolution of a common claim for an earlier year. But here the question for the later years is identical with the question for the earlier year—to wit, what was the hospital's allowable GME costs for the earlier year (the 1984 base year).

> Statutes of limitations, which "are found and approved in all systems of enlightened jurisprudence," [citation omitted], represent a pervasive legislative judgment that *it is unjust to fail to put the adversary on notice* to defend within a specified period of time and that "*the right to be free of stale claims* in time comes to prevail over the right to prosecute them." [Citations omitted.] *These enactments are statutes of repose; . . . they protect defendants and the courts from having to deal with cases in which the search for truth may be seriously impaired by the loss of evidence, whether by death or disappearance of witnesses, fading memories, disappearance of documents, or otherwise.* [Citations omitted.]

United States v. Kubrick, 444 U.S. 111, 117 (1979) (emphasis added).

The Medicare reopening standards were intended to ensure, not impede, accuracy. The reaudit regulation allows exactly what the reopening standards were designed to prevent—the impairment of the "accuracy of the fact-finding process" and the "unjust" treatment of hospitals that had already been put on notice that the determination of 1984 costs was "final and binding." It defies belief that a 1991 audit of a 1984 cost reporting year, conducted two years after that year was closed under long-established Medicare principles, will yield more accurate results than did the 1986 audit of the 1984 cost reporting year. The 1986 audit, unlike the 1991 reaudit, was conducted when 1984 documentation was still readily available, memories of what occurred in 1984 were still fresh, and, in most cases, the financial and medical personnel at the hospital during 1984 were still at the hospital and the intermediary personnel having personal knowledge of the hospital's situation during 1984 were still with the intermediary. Moreover, the 1986 audit was actually an audit of 1984 costs whereas, as discussed above, the 1991 reaudit of "1984"

costs was often largely a "reaudit" not of 1984 but of a subsequent year. 55 Fed. Reg. 36,063-64 (1990).

Significantly, the Secretary has strongly defended Medicare finality principles in the past. For instance, when the Secretary acknowledged in 1986 that her 1979 "malpractice rule" was invalid, she relied on the principle of administrative finality to justify not making corrections to closed years, including PPS base years, stating:

> [T]he general importance of ensuring the finality of decisions on reimbursement issues outweighs whatever benefits might be received by providers whose malpractice insurance costs are outside the reopening period. Our rules of administrative finality and reopening protect both the Medicare Trust Funds and the provider community from unexpected contingencies that might arise long after a decision becomes final. . . . *Regardless of whether our finality and reopening rules benefit or disadvantage providers in a specific case, their overall role of providing certainty in the administrative process is important enough to warrant their consistent application.*

51 Fed. Reg. 11,187 (1986) (emphasis added). The reaudit regulation is hardly in keeping with the Secretary's stated commitment to "consistent application" of the Medicare "finality and reopening standards."

4. ***Absurdity of Inconsistent Base Year Determinations***. Essential to assessing the rationality of the reaudit regulation is the fact that the amounts recognized as reasonable for 1984 were not final when the GME statute was enacted and remained subject to reopening for a period of approximately three years thereafter. Under these circumstances, why would Congress possibly intend that the Secretary make two separate determinations of allowable GME costs under "reasonable cost" principles for the same period of time? An agency may not rationally apply

the very same principles to the very same provider for the very same period of time (1984) to reach two equally valid, but different determinations of allowable costs. If the first determination is final and valid (as the Secretary concedes it is), the later, inconsistent determination must necessarily be invalid. *See, e.g., American Federation of Government Employees, AFL-CIO, Local 3090 v. FLRA*, 777 F.2d 751, 760 (D.C. Cir. 1985) (Scalia, J., concurring) ("I do not think it to be true . . . that an agency is free to take inconsistent positions. . . . It is the agency's responsibility to behave in a rational (and hence reasonably consistent) fashion.")

The Secretary's construction is premised on the absurd proposition that Congress intended that the Secretary wait until 1991 (five years after the enactment of the GME statute), when 1984 years were closed and hospitals were no longer required to retain key supporting documentation, to reaudit 1984 costs for purposes of a methodology that applies to hospital cost reporting years beginning in 1985.[12] Nor does the absurdity of the Secretary's position end there. If the normal rules of Medicare finality do not apply, then there are no constraints on the Secretary. If the Secretary was entitled to reaudit 1984 costs in 1991, what is to prevent her from reauditing 1984 costs again in 1996 or 2001 if she decides that there may have been some

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[12] The absurdity is compounded by the fact that Medicare intermediaries were required to issue NPRs in *1987* for the first years subject to the GME per resident amount methodology. An intermediary is required to issue an NPR "within a reasonable period of time," 42 C.F.R. § 405.1803(a), which is defined as within 12 months of receipt of a provider's perfected cost report, 42 C.F.R. § 405.1835(c). A provider is required to file its cost report within three months of the close of the year for which the report is being filed. 42 C.F.R. § 413.24(f)(2)(i). Thus, for the cost reporting year July 1, 1985-June 30, 1986 (the first year subject to the GME payment methodology), providers were required to file cost reports by September 30, 1986, and the Medicare intermediaries were required to issue NPRs by September 30, 1987. A 1991 reaudit is hardly compatible with this deadline.

problem with the 1991 reaudit? The logic of the Secretary's position would potentially subject hospitals to an endless series of reaudits of 1984 costs.

5. ***Due Process Issues***. As discussed above, over 500 hospitals have appealed the Secretary's per resident amount determinations to the PRRB. The PRRB has scheduled the first hearing for late 1993, and many cases will be heard in 1994. PRRB hearings are likely to continue for much of the remainder of this decade, and the cases will gradually filter into the federal courts nationwide. Because of the Secretary's reaudit regulation, the "search for truth" in these proceedings will undoubtedly "be seriously impaired by the loss of evidence, whether by death or disappearance of witnesses, fading memories, disappearance of documents, or otherwise." *Kubrick*, 444 U.S. at 117. The court of appeals' decision does not serve the goal of ensuring accuracy. The decision, if allowed to stand, will create chaos and deprive hospitals of the fair treatment and repose to which they were lawfully entitled under the Medicare reopening standards and under principles of res judicata.

"The fundamental requisite of due process of law is the opportunity to be heard . . . at a meaningful time and in a meaningful manner." *Goldberg v. Kelly*, 397 U.S. 254, 267 (1970). The 1991 reaudits of closed 1984 years have effectively deprived petitioners and other hospitals of this "opportunity" and have placed hospitals at a tremendous disadvantage. The court of appeals completely failed to consider (or even recognize) the profound "due process" implications of its decision.

The court of appeals ignored serious and compelling issues of administrative finality, res judicata, administrative efficiency, fundamental fairness, and due process. These are important issues worthy of this Court's examination.

D. ***Impermissible Retroactive Rule***. The court of appeals' conclusion that the reaudit regulation is "not an

exercise in retroactive rulemaking" (App. at 15a) is clearly erroneous. The reaudit regulation did not have just "prospective effect," as the court of appeals stated. It is a *1989* rule that required the reaudit of *1984* cost reporting years to be used for a payment methodology that took effect in *1985*; the actual reaudits occurred in *1991* and the Secretary has begun recouping monies from petitioners for the period 1985-1989 based on those reaudits. Thus, this regulation clearly affects reimbursements for *past* periods.

In her court of appeals brief, the Secretary characterized the reaudit regulation as a "modification" of her reopening standards in 42 C.F.R. § 405.1885. Appellant's Brief (filed October 15, 1992) at 21, 31, 32. However, it was a "modification" that occurred after the determination of the amount of 1984 GME costs recognized as reasonable was final and no longer subject to reopening. The Secretary issued a regulation that retroactively made determinations that were already "final and binding" suddenly non-final and non-binding. Moreover, the reaudit regulation also had the effect of retroactively revoking the Secretary's document-retention standards (42 C.F.R. § 405.481(g)(3)). Prior to the reaudit regulation, hospitals were free to discard audit documentation for 1984. The reaudit regulation suddenly placed hospitals in peril if they had done so.[13] Thus, this was not only a retroactive rule, but one of truly extraordinary effect.

In *Bowen v. Georgetown University Hospital*, this Court held that an agency is generally precluded from issuing a retroactive rule absent an "express" statutory grant of retroactive rulemaking authority. 488 U.S. at 208-209. In the GME statute, Congress specified with great care the

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[13] Allowing the intermediaries to reaudit a later cost reporting year was not an appropriate solution. Hospitals were clearly disadvantaged where the physician allocation percentage derived from the later year was less than the physician allocation percentage approved in a final and binding NPR for 1984.

components of the new system with which it was delegating rulemaking authority to the Secretary. For instance, the statute directed the Secretary to establish rules for the computation of the number of FTE residents in an approved medical residency training program. 42 U.S.C. § 1395ww(h)(4)(A). It also authorized the Secretary to "establish" "criteria" for "a geriatric residency or fellowship program." 42 U.S.C. § 1395ww(h)(5)(F)(ii). It also directed the Secretary to "provide for" an allocation of GME costs between the two Medicare trust funds and a per resident amount for hospitals that adopt a teaching program after the GME base year. 42 U.S.C. §§ 1395ww(h)(1), (2)(E). Thus, as the district court noted (App. at 39a-40a), it is clear that when Congress wished to confer retroactive rulemaking authority on the Secretary with respect to the new methodology, it knew very well how to do so. Significantly, however, it did not do so with respect to the 1984 cost component of the new methodology.

The reason why is obvious. The amount to be used as the numerator for the calculation required under 42 U.S.C. § 1395ww(h)(2)(A) was an amount that would be established for 1984 through the already existing audit and reopening procedures. That is why Congress specified the amount "recognized as reasonable *under this subchapter.*" (Emphasis added.)

The Secretary lacked the "express" grant of retroactive rulemaking authority needed under *Georgetown* to issue a retroactive rule. Thus, review by this Court is warranted because the court of appeals' decision presents a clear conflict with this Court's decision in *Georgetown.*

CONCLUSION

The petition for writ of certiorari should be granted.

Respectfully submitted,

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September 28, 1993

APPENDIX

APPENDIX A

UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 92-5281

ADMINISTRATORS OF THE TULANE EDUCATIONAL FUND, d/b/a TULANE MEDICAL CENTER HOSPITAL AND CLINIC,

APPELLEE

v.

DONNA E. SHALALA, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES,

APPELLANT

No. 92-5282

METHODIST HOSPITALS OF MEMPHIS,

APPELLEE

v.

DONNA E. SHALALA, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES,

APPELLANT

No. 92-5283

GEORGE WASHINGTON UNIVERSITY HOSPITAL,

APPELLEE

v.

DONNA E. SHALALA, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES,

APPELLANT

No. 92-5284

LUCY WEBB HAYES NATIONAL TRAINING SCHOOL FOR DEACONESSES AND MISSIONARIES, A CORPORATION

APPELLEE

v.

DONNA E. SHALALA, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES,

APPELLANT

No. 92-5285

GREATER SOUTHEAST COMMUNITY HOSPITAL; FAIRFAX HOSPITAL,

APPELLEES

v.

DONNA E. SHALALA, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES,

APPELLANT

Argued January 19, 1993

Decided March 9, 1993

Appeal from the United States District Court for the District of Columbia

(Civil Action Nos. 92cv01120, 92cv00009, 92cv00041, 92cv00870 and 92cv00989)

Neil H. Koslowe, Attorney, Department of Justice, with whom *Stuart M. Gerson,* Assistant Attorney General, *Jay B. Stephens,* United States Attorney, and *Barbara C. Biddle,* Assistant Director of Appellate Staff, Civil Division, Department of Justice, were on the brief, for appellant.

Ronald N. Sutter for appellees.

Before WALD, RUTH B. GINSBURG and D.H. GINSBURG, *Circuit Judges.*

Opinion for the Court filed by *Circuit Judge* WALD.

WALD, *Circuit Judge:* The Department of Health and Human Services ("HHS" or "agency") appeals the district court's decision invalidating the agency's 1989 regulations implementing a new statutory methodology, enacted by Congress in 1986, for reimbursing teaching hospitals for the graduate medical education ("GME") costs attributable to Medicare services. Under the statute, HHS is to determine, for fiscal year 1984, the average per resident amount of GME costs "recognized as reasonable" for each hospital, and then to use this 1984 base period figure to calculate the hospital's GME reimbursements for all subsequent years. The agency interpreted this statutory directive as permitting it to reexamine and reaudit previously approved, but possibly erroneous or unreasonable, 1984 GME costs, and promulgated reauditing regulations to that effect. Appellees, a group of six hospitals which receive Medicare funds ("Hospitals"),[1] successfully brought a facial challenge to the regulations, arguing that the statutory phrase "amount recognized as reasonable" unambiguously required HHS to employ, without modification, previously approved 1984 GME cost figures, and further, that the agency's reaudit regulations were impermissibly retroactive.

We disagree with the district court that the language of the statute is so plain. Specifically, we do not believe that Congress spoke directly to the precise question of whether HHS should, in determining the base period GME per resident amount, automatically adopt the GME sum approved for reimbursement to hospitals for 1984 or whether it retained the residual authority to reassess at

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[1] The appellees are Methodist Hospitals of Memphis, George Washington University Hospital, Lucy Webb Hayes National Training School for Deaconesses and Missionaries, the Administrators of the Tulane Educational Fund d/b/a Tulane Medical Center Hospital and Clinic, Greater Southeast Community Hospital, and Fairfax Hospital.

a later date the reasonableness of that calculation for prospective use only. Given this ambiguity, we find that HHS reasonably determined that Congress would not likely have wished misclassified and nonallowable costs inadvertently reimbursed to hospitals for fiscal year 1984 to be "cemented" into the base period amount and indefinitely carried forward in the formula for future reimbursements. To avoid that eventuality, HHS must retain the ability to revisit its 1984 reimbursements for error, even though those figures had previously been found reasonable, since the sole purpose of the reauditing was to calculate the base period formula applicable under the 1986 statute for fiscal year 1985 and later years. Under those circumstances, the readjustment of the 1984 figures did not constitute impermissible retroactive rulemaking. For these reasons, we reverse the district court and uphold the agency's regulations.

I. BACKGROUND

Health care providers that participate in the Medicare program are eligible to be reimbursed for medical education costs associated with an approved GME program that relate to Medicare services. Under previous HHS regulations, providers were required each fiscal year to file a "cost report," including GME costs, with a "fiscal intermediary" designated by HHS. 42 C.F.R. § 405.1801. The intermediary then determined the total amount of reimbursement due the provider in the form of a "notice of program reimbursement" ("NPR"), 42 C.F.R. § 405.1803, which could be challenged by the provider before the Provider Reimbursement Review Board ("Board"). 42 U.S.C. §§ 1395oo(a), (b); 42 C.F.R. §§ 405.1835, 405.1837. The Secretary of HHS could timely reverse, affirm or modify a Board decision. 42 U.S.C. § 1395oo(f)(1). By regulation, the Secretary also could, within three years, reexamine any determination by a fiscal intermediary, the Board or the Secretary. 42 C.F.R. § 405.1885. Finally,

providers were entitled to obtain judicial review of Board decisions and any reversal, affirmance or modification by the Secretary. 42 U.S.C. § 1395oo(f)(1).

Until 1985, hospitals were reimbursed for GME costs under a "reasonable cost" system, 42 U.S.C. § 1395f(b)(1), but in 1985, the HHS promulgated new regulations specifying that hospitals would thereafter be reimbursed for the lesser of allowable costs for the current year or the hospitals' approved costs incurred during fiscal year 1984. 50 Fed. Reg. 27,722 (1985). However, in 1986, Congress itself passed Pub. L. No. 99-272, 100 Stat. 153-155 *et seq.*, 42 U.S.C. § 1395ww(h) ("GME Amendments") which established a new methodology for calculating reimbursements for all periods beginning on or after July 1, 1985. The statute required HHS to first

> determine, for the hospital's cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this subchapter for direct graduate medical education costs of the hospital for each full-time-equivalent resident.

42 U.S.C. § 1395ww(h)(2)(A). Thus, HHS was directed to calculate a per resident amount for each hospital by dividing the amount of GME costs recognized as reasonable for the base period of 1984 (numerator) by the number of full-time equivalent ("FTE") interns and residents working at the hospital in 1984 (denominator). For hospitals that had no approved medical residency training program or did not participate in Medicare in 1984, HHS was to determine the "appropriate" per resident amount. 42 U.S.C. § 1395ww(h)(2)(E). To determine a hospital's GME reimbursement for 1985 and future years, the 1984 base period per resident amount, adjusted for inflation, would be multiplied by the number of FTE residents working in the hospital during the year in question, and that product would be multiplied by the hospital's Medicare patient load in the same year. 42 U.S.C. § 1395ww(h)(3).

By 1989, when HHS promulgated regulations to implement the 1986 GME Amendments, virtually all hospitals had already received NPRs for 1984, and in most cases, the regulatory three year reopening period had expired. Nevertheless, the new regulations permitted the fiscal intermediaries to reaudit the 1984 GME costs and "exclude[] from the base-period graduate medical education costs any nonallowable or misclassified costs," for purposes of determining the "base-period per resident amount." 42 C.F.R. § 413.86(e)(1)(ii). Acknowledging that the three year reopening period had expired for most hospitals, the Secretary stressed that the regulations "indicate[d] that if a hospital's base-period cost report is no longer subject to reopening under § 405.1185, the intermediary may modify the hospital's GME base-period costs *solely* for purposes of computing the per resident amount," and not to adjust the amount owed under the 1984 NPR. 54 Fed. Reg. 40,301 (emphasis added); *see* 42 C.F.R. §§ 413.86(e)(1)(iii). Moreover, the Secretary assured hospitals that "no new reimbursement principles will be applied during the reaudit. Rather, our intent is to ensure that the reimbursement principles in effect during the GME base period were correctly applied." 54 Fed. Reg. 40,301 (1989). Finally, hospitals were given 180 days to appeal any determination of their base period per resident amount. 42 C.F.R. § 413.86(e)(1)(v).

In 1990, the intermediaries began reauditing hospitals' cost reports and found that the allowable 1984 GME amount for each of the six appellee Hospitals was lower than the amount previously approved.[2] For instance, the

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[2] The Hospitals complain that they were only required to retain certain records relevant to the reimbursement calculation for four years after the end of a cost reporting period, 42 C.F.R. § 405.481(g), and therefore, at the time of reauditing, some no longer had this documentation. *See* Appellee's Brief at 9. HHS has responded by permitting the fiscal intermediaries, where necessary, to use records from later

fiscal intermediary for Methodist Hospitals of Memphis ("Methodist") determined that Methodist's allowable 1984 GME costs were $2,785,809, $893,841 less than the $3,679,650 approved by the intermediary in an NPR issue in 1986. Because more than three years had passed since the time the NPRs became final, the reaudits did not result in any recoupment of reimbursements for 1984 but only affected the base period calculation. Methodist appealed to the Board and filed a motion for expedited judicial review on the ground that the Board lacked authority to pass on the validity of the agency's regulations. By statute, the Board has thirty days to rule on such a motion, 42 U.S.C. § 1395oo(f)(1), and when that period expired without a ruling by the Board,[3] Methodist, joined by the five other appellees, filed the present action in district court, challenging the legality of the regulations. The district court ruled for the Hospitals on summary judgment, finding the regulations invalid as contrary to the plain meaning and intent of the GME Amendments and as an unauthorized retroactive rule. *Methodist Hospitals v. Sullivan,* Civil Action Nos. 92cv01120, 92cv00009, 92cv00041, 92cv00870, 92cv00989 Memorandum Opinion ("Mem. op.") (D.D.C. July 17, 1992). The Secretary now appeals that decision.[4]

II. ANALYSIS

A. *Statutory Intent*

Under the familiar *Chevron* two-step analysis for reviewing an agency's construction of a statute, we ask first

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years for purposes of calculating the 1984 per resident amount. *See* 55 Fed. Reg. 36,063-64 (1990). The Hospitals do not directly challenge this practice in the present litigation, but they urge that the need to resort to this procedure is evidence of the irrationality of HHS's regulations.

[3] The Board issued an order denying expedited judicial review but did not rule on the validity of the reauditing regulations.

[4] On appeal, the HHS does not question the district court's subject matter jurisdiction. *See* Appellant's Brief at 3 n.2.

"whether Congress has directly spoken to the precise question at issue," and if not, we consider whether the agency's interpretation of the question left open by the statute is a reasonable one. *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-44 (1984). Here the district court was confronted with the task of interpreting the statutory directive that HHS "determine, for the hospital's cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this subchapter for direct graduate medical education costs of the hospital for each full-time-equivalent resident." 42 U.S.C. § 1395ww(h)(2)(A). The district court went no further than the first *Chevron* step, concluding that the statutory phrase "amount recognized as reasonable" clearly mandated that HHS use as the base for future payments the 1984 GME costs previously approved by the agency, and that "the plain meaning of the statute does not authorize a reaudit of the 1984 base year costs." Mem. op. at 15. We, however, find it necessary to proceed to the second *Chevron* station because we are not persuaded that the statutory phrase is without ambiguity in the context of the 1986 GME Amendments.

The Hospitals argue their case for nonambiguity on several fronts. First they say, and the district court held, "Congress could not have intended that the Secretary interpret 'recognized as reasonable' to mean two amounts for fiscal 1984: one derived from the standard cost reporting and review process following the close of the fiscal year; and a lower figure recalculated once the Secretary realized that the year would become the base-year for subsequent determinations." Mem. op. at 18. In the district court's view, "[i]f the figures were 'recognized as reasonable' for the purpose of determining the costs in fiscal year 1984, they must also be recognized as reasonable for subsequent years." *Id.* at 17. The issue thus devolves into whether, assuming its knowledge of the long-standing regulation providing for a three year period for reopening

approved costs, 42 C.F.R. § 405.1885, Congress in enacting the 1986 GME Amendments left some leeway for the eventuality that HHS might not be able to promulgate and implement regulations governing the new methodology until after that three year period had lapsed, or whether, even if the new regulations should be delayed until after the three year period, Congress clearly intended to prohibit the Secretary from reauditing the 1984 GME costs for past errors in order to establish an accurate base period per resident amount. The statutory text certainly does not address this administrative dilemma directly, and the Hospitals cite to no legislative history to show that Congress had any intent at all about it. HHS, predictably but persuasively, took the position in promulgating the reaudit regulation that it is "hard to believe that Congress intended that misclassified and nonallowable costs continue to be recognized through the GME payment indefinitely." 54 Fed. Reg. 40,301 (1989). Indeed, since the GME Amendments were enacted for the purpose of establishing a new and presumably more accurate methodology for reimbursing GME costs, the most natural assumption to be drawn from the statutory silence on the subject would be that Congress did not mean to preclude HHS from correcting past mistakes in the 1984 figure which would govern subsequent payments. In sum, we can find no convincing evidence, direct or indirect, that Congress meant to prohibit corrective reauditing of the 1984 GME cost figures.[5]

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[5] The district court also intimated, though the Hospitals do not argue it on appeal, that the fact that Congress did not expressly delegate to the HHS rulemaking authority to determine the "amount recognized as reasonable," whereas it did so authorize the HHS to "establish rules" for computing the number of FTE residents, supports the conclusion that Congress did not intend to allow any reauditing. Mem. op. at 19 (citing 42 U.S.C. § 1395ww(h)(4)(A)). But the two situations are quite different and justify different statutory treatments. The FTE figure was an entirely new concept in the GME Amendments and required HHS to establish a procedure for its calculation. By contrast, the concept of reasonable costs already was a mainstay of Medicare statutes

As a second arrow in their quiver, the Hospitals rely heavily on our decision in *Georgetown University Hospital v. Bowen*, 862 F.2d 323 (D.C. Cir. 1988) ("*Georgetown II*"), which involved a statutory four year transition period beginning in 1983 for shifting from a "reasonable cost" to a "prospective payment" system for Medicare reimbursement of hospital in-patient operating costs. Under the statutory scheme, HHS was to determine reimbursement using hospital-specific rates calculated on the basis of "the allowable operating costs of in-patient hospital services . . . recognized under this subchapter for such hospital for the preceding 12-month cost reporting period." 42 U.S.C. § 1395ww(b)(3)(A). The HHS regulations, however, provided that when a hospital successfully appealed an intermediary's estimation of the 12-month base period costs to the agency or to a court, the finally approved figure would be used as the reimbursement base only in the phase-in year *following* the final decision on review. *Georgetown II*, 862 F.2d at 325. We said, however, in overturning those regulations, that by "allowable" costs Congress meant costs incurred during the reporting period that were finally determined to be allowable after all statutorily-authorized administrative and/or judicial review had been exhausted. *Id.* at 326-27; *see also Tucson Medical Ctr. v. Sullivan*, 947 F.2d 971, 976 (D.C. Cir. 1991). On a "turnabout is fair play" rationale, the Hospitals argue here that an administratively "final" determination that a hospital's 1984 GME costs were reasonable precludes any later reassessment, for any purpose, of that same year's costs.

Georgetown II, while obviously involving similar subject matter, has little bearing on the specific issues in debate here. In that case, we construed the phrase "allowable operating costs . . . recognized under this subchapter" to

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and regulations, *see* 42 U.S.C. § 1395x(v), 42 C.F.R. § 405.1803, and there was no need to establish any new rulemaking authority for its determination.

require HHS to apply a final administrative or judicial decision on the allowability of a particular cost retrospectively to the year under appeal. We simply did not believe that Congress intended that "preliminary estimates [of allowable costs], although administratively necessary, would somehow become final and unalterable before the review process under the statute had been completed." 862 F.2d at 327. The logic underlying our conclusion there was very different from that pressed upon us here by the Hospitals, *i.e.*, that the directive in the GME Amendments to determine the "amount recognized as reasonable" for 1984 precludes HHS from ever reauditing that cost determination *for purposes of computing a base period figure for use in succeeding years.* HHS is in no way attempting here to "effectively cement[] unlawful calculations into the transition year payments by largely insulating them from review," as it was in *Georgetown II.* 862 F.2d at 328. Just the opposite. It is attempting to ensure that misclassified and nonallowable costs approved in NPRs for 1984 are *not* cemented indefinitely into future GME cost reimbursements.

Finally, and perhaps most importantly, the relevant phrase "amount recognized as reasonable under this subchapter" *is* on its face ambiguous. We know only one thing for sure, that it certainly could not have included any amounts already finally approved before the statute was enacted since, in 1986, every hospital's 1984 NPR was still subject to the three year reopening period. *See* 42 C.F.R. § 405.1885. But beyond that given, it is decidedly unclear that the statute meant to allow the Secretary to use only the GME cost figure that would emerge as reasonable through the regular NPR review and three year reopening process. It might just as well have permitted the Secretary the option of using a figure that would be "recognized as reasonable under this title" at a later time after more careful assessment. *See also Dept. of Treasury v. FLRA,* 960 F.2d 1068, 1072 (D.C. Cir. 1992) ("[The statutory

phrase] 'adversely affected' is simply an adjectival phrase, not a verbial phrase indicating the past tense, and hence allows alternative temporal readings. The language, in short, is ambiguous . . . .").[6] In our own review of the statutes governing Medicare reimbursement, we have uncovered at least two other occasions in which Congress has used the phrase "recognized as reasonable." Section 1395x(v), pertaining to the manner in which HHS determines a cost to be reasonable, permits the Secretary to "provide for the establishment of limits [on certain costs] *to be* recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services." 42 U.S.C. § 1395x(v)(1)(A) (emphasis added). Section 1395uu, concerning payments to promote the closing or converting of under-utilized hospital facilities, provides that the Secretary, in determining the hospital's proper "transitional allowance," recognize "the outstanding portion of actual debt obligations *previously* recognized as reasonable for purposes of reimbursement." 42 U.S.C. § 1395uu(c)(1)(B) (emphasis added). We refer to these sections only to suggest that the phrase "recognized as reasonable," by itself, does not tell us whether Congress means to refer the Secretary to action already taken or to give directions on actions about to be taken. Context is all, and in this case, we believe the use of the 1984 figures for the indefinite future cautions us against a reading of the phrase that allows no elbow room for adjustments based on prior miscalculations or errors.

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[6] We also note that because the statute directs the HHS to "*determine*" the "*average* amount" of GME costs per FTE resident "recognized as reasonable," it seems unlikely that Congress intended for the HHS to simply look up a hospital's approved NPR for 1984 and plug it into the statutory formula. This activist language suggests that Congress must have intended for the agency to make some kind of substantive calculation on its own, which might involve as well a current assessment of the reasonableness of prior determinations.

Because we agree with HHS that "the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute." *Chevron*, 467 U.S. at 843.

B. *Reasonableness*

In its proposed regulations to implement the GME Amendments, HHS reasoned that "[b]ecause the payment methodology required by [the statute] sets future payments using the Federal FY 1984 base-period amounts as the initial starting point, we believe that it is very important that inappropriate costs not be included in the base-period amount." 53 Fed. Reg. 36,591 (1988). The agency believed that it had erroneously reimbursed hospitals for various "misclassified" and "nonallowable" costs from fiscal year 1984, *id.* at 36,591-92, and that these errors explained in part why "the range of per resident amounts for the GME base year varies from below $10,000 to over $100,000 per resident," *id.* at 36,593. As an example of a misclassified cost, the Secretary cited "physicians' compensation costs for services to the hospital that are not specifically and directly related to approved educational activities," and as an illustration of a nonallowable cost, the agency referred to "the costs of a medical school related to a hospital by common ownership or control . . . that are not directly and specifically related to patient care furnished in the hospital." *Id.* at 36,591-92. The Secretary concluded that the GME Amendments "would seem to require that we correct these discrepancies in the base period since there is no provision in the law for correcting them later." *Id.* at 36,593.

In the preamble to the regulations, the Secretary responded to a comment that concerns about past erroneous reimbursements were "unfounded," by citing "several situations . . . brought to our attention in which physicians' costs incurred for activities unrelated to GME . . . costs

[were] misclassified as GME costs or excessive administrative and general service costs were allocated to the GME cost center." 54 Fed. Reg. 40,300 (1989). The Secretary based the need for reauditing on the fact that "GME costs were not given sufficient scrutiny at the time because of the many changes taking place in Medicare generally." *Id.* at 40,301. Finally, the Secretary reiterated that the 1984 GME costs should be revisited because it was "hard to believe that Congress intended that misclassified and nonallowable costs continue to be recognized through the GME payment indefinitely." *Id.*

The agency's belief that Congress would resist permanently ingraining misclassified and nonallowable costs in future reimbursements to health care providers can hardly be deemed unreasonable or inconsistent with the congressional purpose of erecting a new and more accurate reimbursement methodology. *See generally Shell Oil Co. v. EPA*, 950 F.2d 741, 755 (D.C. Cir. 1991); *Ohio v. Dep't of the Interior*, 880 F.2d 432, 441 (D.C. Cir. 1989). The agency described its concerns on the rulemaking record and reasonably interpreted a statutory ambiguity to permit reauditing of 1984 GME costs in determining the "average amount recognized as reasonable" for the GME costs of each FTE resident. Moreover, recognizing that its own three year window for reassessing NPRs for 1984 had closed, the agency reasonably determined that its reauditing should only impact the base period per resident amount calculation that, by statute, would be used to compute reimbursements from 1985 onward. We do not accept, therefore, the Hospitals' argument that the agency acted unreasonably in failing to reaudit their 1984 GME costs within the three year regulatory reopening period. The three year gap between the 1986 enactment of the GME Amendments and promulgation of the agency's regulations in 1989, while unfortunate, was not an unreasonable period for developing, proposing, permitting comment, and fin-

alizing a regulatory framework for a complex statutory scheme.[7]

C. *Retroactivity*

As an alternative ground for its decision invalidating the agency's reauditing regulations, the district court found the regulations to be impermissibly retroactive because they allegedly lacked specific authorization in the statute. Mem. op. at 20-22. Because the 1986 GME Amendments require HHS to determine "an approved FTE resident amount for each cost reporting period beginning on or after July 1, 1985," 42 U.S.C. § 1395ww(h)(2), the statute, by its very terms, is intended to have some retroactive effect. *See Kaiser Aluminum & Chem. Corp. v. Bonjorno*, 494 U.S. 827, 837 (1990) (regarding retroactivity, "where the congressional intent is clear, it governs"). Accordingly, any regulations implementing the statute will necessarily be retroactive *insofar* as they will alter the methodology for reimbursements beginning in 1985. *See Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 208 (1988) ("*Georgetown I*") ("[C]ongressional enactments and administrative rules will not be construed to have retroactive effect unless their language requires this result."). However, that does not answer the separate question of whether reauditing the 1984 GME cost figures to determine a base period amount for computing payments from 1985 forward is improperly retroactive. We conclude that the reauditing is not an exercise in retroactive rulemaking at all, let alone an impermissible one. The reaudit carries no impact for actual 1984 reimbursements and will be used only to calculate future reimbursements. A law is retroactive if it " 'takes away or impairs vested rights acquired under existing law, or creates a new obligation, imposes a new duty, or at-

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[7] We address here only the *facial* validity of HHS's reauditing regulations. Each hospital has 180 days after the calculation of its base period per resident amount to challenge the accuracy of any determination before the Board. 42 C.F.R. § 413.86(e)(1)(v).

taches a new disability in respect to transactions or considerations already past.' " *Ass'n of Accredited Cosmetology Sch. v. Alexander*, 979 F.2d 859, 864 (D.C. Cir. 1992) (quoting *Neild v. Dist. of Columbia*, 110 F.2d 246, 254 (D.C. Cir. 1940) (internal quotations omitted)). The Secretary's reauditing regulations do none of these things.

In *Association of Accredited Cosmetology Schools*, a new statute and its implementing regulations made past loan default rates an acceptable basis for terminating schools from a federally guaranteed student loan ("GSL") program, even though those rates were permissible under prior law. 979 F.2d at 859. We explained:

> Instead of undoing past eligibility, . . . the Act and the regulations merely require the Department [of Education] to look at schools' past default rates in determining future eligibility for GSL program participation. We regard this requirement as no different in substance than a lender's rule against extending credit to applicants with negative credit histories. Several cases have established that such a requirement does not operate retroactively. *See Reynolds v. United States*, 292 U.S. 443, 449 (1934)) (holding that "[a] statute is not rendered retroactive merely because the facts or requisites upon which its subsequent action depends, or some of them, are drawn from a time antecedent to the enactment"); *Neild v. District of Columbia*, 110 F.2d 246, 255 (D.C. Cir. 1940) (holding that a law is not retroactive simply because it depends on " 'antecedent facts for its operation' ") (quoting *Lewis v. Fidelity & Deposit Co.*, 292 U.S. 559, 571 (1934)). . . . We accordingly hold . . . that the Act and the regulations are not retroactive.

Id. at 865-66; *see also Campbell v. United States*, 809 F.2d 563, 571 (9th Cir. 1987).

The situation is similar here. Rather than altering 1984 reimbursements, HHS's regulations simply permit the Secretary to use reaudited versions of those past figures for the purpose of determining reimbursements in succeeding years. *Cf. Georgetown I,* 488 U.S. at 204 (regulation which changed reimbursement methodology and allowed HHS to recoup past payments under new methodology deemed impermissibly retroactive). Although in this case the GME Amendments themselves operate retroactively to alter the reimbursement methodology from July 1, 1985 onward, that contextual difference does not make the use of the reaudited 1984 figures in the new methodology retroactive in its own right. To put it another way, within the limited statutory retroactivity, the Secretary's reauditing regulations add nothing further that is retroactive: the regulations contemplate only the use of past information for subsequent decisionmaking. "In view of that conclusion, we need not consider [the Hospitals'] argument that . . . the [statute] does not speak with the requisite clarity to justify retroactive rulemaking." *Ass'n of Accredited Cosmetology Sch.,* 979 F.2d at 866.

III. CONCLUSION

For the foregoing reasons, we reverse the district court and uphold the facial validity of HHS's reauditing regulations.

So ordered.

APPENDIX B

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

Civil Action No. 92-0009

METHODIST HOSPITALS OF MEMPHIS,
Plaintiff,

v.

LOUIS SULLIVAN, M.D., Secretary, Department of Health and Human Services,
Defendant.

Civil Action No. 92-0041

GEORGE WASHINGTON UNIVERSITY HOSPITAL,
Plaintiff,

v.

LOUIS SULLIVAN, M.D., Secretary, Department of Health and Human Services,
Defendant.

Civil Action No. 92-0870

LUCY WEBB HAYES NATIONAL TRAINING SCHOOL FOR DEACONESSES AND MISSIONARIES,
Plaintiff,

v.

LOUIS SULLIVAN, M.D., Secretary, Department of Health and Human Services,
Defendant.

Civil Action No. 92-1120

THE ADMINISTRATORS OF THE TULANE

EDUCATIONAL FUND d/b/a TULANE MEDICAL CENTER HOSPITAL AND CLINIC,

Plaintiff,

v.

LOUIS SULLIVAN, M.D., Secretary, Department of Health and Human Services,

Defendant.

Civil Action No. 92-0989

GREATER SOUTHEAST COMMUNITY HOSPITAL, *et al.*,

Plaintiffs,

v.

LOUIS SULLIVAN, M.D., Secretary, Department of Health and Human Services,

Defendant.

ORDER

In accordance with the Memorandum Opinion entered this day, it is by the Court, this 17th day of July, 1992, hereby

ORDERED that Defendant's Motion to Dismiss is denied; and it is

ORDERED that Defendant's Motion for Summary Judgment is denied; and it is

ORDERED that Plaintiffs' Motion for Summary Judgment is granted, except that plaintiffs' Motion for Summary Judgment with respect to PRRB's policy not to disclose dissenting opinions is denied; and it is

ORDERED that Plaintiffs' Motion to Compel Production is granted; and it is

FURTHER ORDERED that the Secretary's reaudit regulation, 42 C.F.R. 413.86(e)(ii), is unlawful as it conflicts with the plain meaning of 42 U.S.C. § 1395ww(h)(2)(A) and is an impermissible retroactive rule.

/s/ John H. Pratt
JOHN H. PRATT
United States District Judge

APPENDIX C

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

Civil Action No. 92-0009

METHODIST HOSPITALS OF MEMPHIS,
Plaintiff,

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LOUIS SULLIVAN, M.D., Secretary, Department of Health and Human Services,
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LUCY WEBB HAYES NATIONAL TRAINING SCHOOL FOR DEACONESSES AND MISSIONARIES,
Plaintiff,

v.

LOUIS SULLIVAN, M.D., Secretary, Department of Health and Human Services,
Defendant.

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THE ADMINISTRATORS OF THE TULANE

EDUCATIONAL FUND d/b/a TULANE MEDICAL CENTER HOSPITAL AND CLINIC,

Plaintiff,

v.

LOUIS SULLIVAN, M.D., Secretary, Department of Health and Human Services,

Defendant.

Civil Action No. 92-0989

GREATER SOUTHEAST COMMUNITY HOSPITAL, *et al.*,

Plaintiffs,

v.

LOUIS SULLIVAN, M.D., Secretary, Department of Health and Human Services,

Defendant.

MEMORANDUM OPINION

These cases concern a Medicare regulation that implements a new statutory payment methodology for graduate medical education ("GME") costs borne by teaching hospitals. The regulation in question is a retroactive rule published in late 1989 that permits the Secretary of Health and Human Services ("Secretary") to reaudit hospitals' 1984 graduate medical education costs. Plaintiffs contend that the Secretary's regulation is invalid as contrary to the plain meaning of the statute, as an invalid retroactive rule, and as an arbitrary and capricious act.

Defendant claims that this Court lacks subject matter jurisdiction as administrative remedies are not yet final, and that in any case, the regulation at issue is valid.

Before this Court are defendant's motion to dismiss, and plaintiffs' and defendant's motions for summary judgment. In addition, plaintiffs have filed a motion to compel production. For the reasons that follow, we find that we have jurisdiction over this dispute and consequently deny

defendant's motion to dismiss on jurisdictional grounds. On the merits, we grant plaintiffs' motion for summary judgment with the exception that we deny plaintiffs' motion for summary judgment with respect to PRRB's policy not to disclose dissenting opinions in EJR determinations and we deny defendant's motion for summary judgment.

I. Background

On April 7, 1986, Congress enacted Pub. L. No. 99-272, 100 Stat. 153-55 *et seq.*, 42 U.S.C. § 1395ww(h), which established new rules for reimbursing graduate medical education costs of hospitals participating in Medicare. The law provides for the Secretary to determine for each hospital an approved per resident amount for each cost reporting period beginning on or after July 1, 1985.[1] The per resident amount is the average amount recognized as reasonable during a base period that began in fiscal year 1984, updated each year by an inflation factor.[2]

The regulations implementing the GME reimbursement rules established in the 1986 statute were issued on September 29, 1989. *See* 54 Fed. Reg. 40286 (codified at 42 C.F.R. § 413.86). Fiscal intermediaries[3] were instructed to determine the base period average per resident amount and hospitals were authorized to appeal the determination within 180 days of the notice. 42 C.F.R. § 413.86(e)(1)(v). The challenged regulations provided that the fiscal inter-

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[1] For cost reporting periods beginning prior to July 1, 1985, Medicare reimbursed hospitals according to reasonable cost principles.

[2] 42 U.S.C. § 1395ww(h)(2)(A). To determine the GME payment for a cost reporting period year beginning on or after July 1, 1985, the Secretary multiplies that hospital-specific per resident amount by the weighted average number of full-time-equivalent ("FTE") residents in the hospital's residency program for the particular period. The Secretary then multiplies that number by the hospital's Medicare patient load for that period. 42 U.S.C. § 1395ww(h)(3).

[3] Fiscal intermediaries are generally private insurance companies under contract to the government.

mediaries "verify" or reaudit the hospital's base period GME costs in fiscal 1984 and "modify" the base period costs that would be used in computing the hospital-specific per resident amount. 42 C.F.R. § 413.86(e)(1)(ii).[4] Under standard Medicare reimbursement procedures, the Secretary has three years from the issuance of the notice of program reimbursement ("NPR") to correct for inappropriate or misidentified costs. *See* 42 C.F.R. § 405.1885. The challenged regulation provides that if the hospital's cost report for its GME base year is no longer subject to reopening under 42 C.F.R. § 405.1885, the intermediary may apply the results of the reauditing only for purposes of the GME per resident amount methodology and not for the base year itself. 42 C.F.R. § 413.86(e)(1)(iii). After completing the reaudits, the intermediaries are to issue to each hospital a notice of "its base period average per resident amount". 42 C.F.R. § 413.86(e)(1)(v). Hospitals, if dissatisfied with the intermediary's determination, have 180 days from the date of the notice to file an appeal with the Provider Reimbursement Review Board ("PRRB"). 42 C.F.R. § 413.86(e)(1)(v).

Plaintiffs in this action are six teaching hospitals whose allowable GME costs were found to be lower on reaudit than their 1984 base year cost report would indicate.[5] The

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[4] Generally, under Medicare, a provider of services must provide a cost report to its intermediary at the close of a fiscal year. The report will include the costs incurred during the fiscal year and the appropriate share of the costs to be apportioned to Medicare. 42 C.F.R. §§ 413.20(b), 413.24(f); *Tucson Medical Center v. Sullivan*, 947 F.2d 971, 974 (D.C. Cir. 1991). The intermediary then analyzes the cost report and informs the provider of a final determination of the amount of Medicare reimbursement. *Id.* at 974. A provider who is dissatisfied may appeal the determination with the Provider Reimbursement Review Board ("PRRB") within 180 days of the date of the notice of program reimbursement. *Id.*

[5] The hospitals include the Greater Southeast Community Hospital located in Washington, D.C.; Fairfax Hospital located in Virginia; Meth-

suits were consolidated since the issues presented are identical. They bring this suit against Louis Sullivan, the Secretary of Health and Human Services.

The experiences of Methodist Hospitals of Memphis ("Methodist") and George Washington University Hospital ("GWU") are illustrative. On February 26, 1991, Blue Cross and Blue Shield ("BCBS") of Tennessee sent Methodist a notice of its per resident cost for the fiscal year ending December 31, 1984. BCBS determined that Methodist's allowable GME costs were $893,841 less than the amount determined by the 1986 audit of Methodist's 1984 cost report. Methodist did not have to refund the difference for 1984: however, the 1991 notice established the per resident amount to be used in calculating its GME payment for post-July 1, 1985 years. Similarly, GWU's costs were assessed at $8,861,049 for the fiscal year ending June 30, 1985, $4,236,299 lower than its previous audit.

These two hospitals appealed on August 12 and August 13, 1991 to the PRRB.[6] While the appeals were pending, the hospitals petitioned the PRRB for a determination that the PRRB had no authority to decide the issue of the validity of the Secretary's GME regulations, and that Expedited Judicial Review (EJR) would be appropriate. The PRRB found that the appeals involved mixed issues of law and fact and concluded that it should retain jurisdiction of the appeal. It denied the hospitals' petitions for EJR on November 8, 1991. Two of the five PRRB members

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odist Hospitals of Memphis; George Washington University Hospital located in Washington, D.C.; Tulane Medical Center Hospital in Louisiana; and the Sibley Memorial Hospital of Washington, D.C.

[6] They appealed on two grounds: that the intermediaries should have calculated the per resident amount on the basis of GME costs determined in the initial 1986 audits, rather than the 1990 verifications, and second, they challenged the merits of the 1990 adjustments to the base period cost reports.

dissented from the majority opinion; however, under new PRRB policy, their opinion was not published.

Plaintiffs contend that the Secretary's regulations are invalid insofar as they permit a determination of allowable GME base year costs for purposes of the per resident amount methodology under section 1886(h) of the Act that differ from the final, audited cost report for the GME base year itself. Specifically, plaintiffs argue that the plain wording of the statute mandates that the GME payment rate be based on the GME costs found to be reasonable for the GME base year, and that the regulation providing otherwise is invalid. They argue that the Secretary did not possess the express authority to issue a retroactive rule and that the reaudit regulation is arbitrary and capricious.

II. Jurisdictional Argument

Defendant in its motion to dismiss first claims that we are without jurisdiction to entertain this suit. Defendant argues that this Court is without subject matter jurisdiction to review the PRRB's denial of EJR status. Defendant bases this argument on the statutory language of the EJR provision, 42 U.S.C. § 1395oo(f)(1), and on the agency's implementing regulations. Specifically, defendant contends that the statute explicitly provides for judicial review if the PRRB determines that it lacks jurisdiction (a decision, in effect, that EJR would be appropriate), but that the statute does not provide district court jurisdiction in cases where the PRRB turns down an EJR request. We resolve this question by referring to the language and the legislative history of the statutory provision.

In 1972, Congress created the Medicare reimbursement appeals process. Pub. L. No. 92-603, § 243(a), 86 Stat. 1420 (1972). As originally enacted, the statute required that a provider obtain a decision on the merits of all issues from the PRRB before it could seek judicial review. *See, e.g., Association of American Medical Colleges v. Califano*, 569

F.2d 101, 110 (D.C. Cir. 1977). However, as the PRRB must follow Medicare regulations and rulings, *see Bethesda Hospital Association v. Bowen*, 485 U.S. 399, 406-07 (1988); 42 C.F.R. § 405.1867, the Board could not invalidate a Medicare regulation. As a result, any challenge to the regulation itself was delayed while the provider obtained a determination from the PRRB.

In 1980, Congress amended section 1878(f)(1) of the Social Security Act, 42 U.S.C. § 1395oo(f)(1), to provide for expedited judicial review of Medicare regulations. Under the statute, the provider may petition the Board for a determination that it lacks jurisdiction, or the Board may decide *sua sponte* that it lacks such jurisdiction. Upon such a determination, the provider is permitted to file a judicial action seeking review of the appropriate regulation.

Quite simply, plaintiffs contend that they followed the appropriate procedural requirements to obtain expedited judicial review and that this Court has jurisdiction to review the regulation at issue pursuant to section 1878(f)(1), 42 U.S.C. § 1395oo(f)(1). Defendant claims that the statute and Medicare regulations do not provide for expedited judicial review where the PRRB does not explicitly permit it. We believe that defendant's interpretation of the statute is strained, and that we do have jurisdiction pursuant to 42 U.S.C. § 1395oo(f)(1) to hear this dispute.

To determine if this Court has jurisdiction to review, we first turn to the language of the statute. If Congress has spoken directly to the issue at question, "that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress." *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-43 (1984). In construing congressional intent, we look to both statutory language and legislative history, and the court is " 'not required to grant any particular deference to the agency's parsing of statutory language or its interpretation of leg-

islative history.' " *Washington Hospital Center v. Bowen*, 795 F.2d 139, 143 (D.C. Cir. 1986) (quoting *Rettig v. Pension Benefit Guaranty Corp.*, 744 F.2d 133, 141 (D.C. Cir. 1984)). Section 1878(f)(1) of the Social Security Act, 42 U.S.C. § 1395oo(f)(1), which is hardly a model of clarity, provides:

> [1] A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. [2] Providers shall have the right to obtain judicial review of any final decision of the Board, or of any reversal, affirmance, or modification by the Secretary, by a civil action commenced within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance, or modification by the Secretary is received. [3] Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by civil action commenced within sixty days of the date on which notification of such determination is received. [4] If a provider of services may obtain a hearing under subsection (a) and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). [5] The Board shall render such deter-

> mination in writing within thirty days after the Board receives the request and such accompanying documents and materials, and the determination shall be considered a final decision and not subject to review by the Secretary. [6] If the Board fails to render such determination within such period, the provider may bring a civil action (within sixty days of the end of such period) with respect to the matter in controversy contained in such request for a hearing. [7] Such action shall be brought in the district court of the United States for the judicial district in which the provider is located (or, in an action brought jointly by several providers, the judicial district in which the greatest number of such providers are located) or in the District Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of title 5, United States Code, notwithstanding any other provisions in section 205. [8] Any appeal to the Board for action for judicial review by providers which are under common ownership or control or which have obtained a hearing under subsection (b) must be brought by such providers as a group with respect to any matter involving an issue common to such providers.[7]

We think it clear that the statute provides for our jurisdiction. The fourth and fifth sentence dictate that once a provider has filed a request for "a determination by the Board of its authority to decide the question of law or regulations", the Board must issue its determination within thirty days after receiving the request and accompanying documents and materials. The sixth sentence provides that if the Board does not render its determination within thirty

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[7] Clauses numbered for ease of analysis.

days, the provider may bring a civil action within the next sixty days.

Plaintiffs complied with all of the procedural requirements; they filed their request as well as additional information and material to aid the Board in determining whether it had authority to decide the issue.[8] The Board denied Methodist's request for an EJR determination on November 8, 1991, within the 30-day period, stating that

> the audit adjustments in dispute contain factual issues for the Board to decide which are all related to the legal issue raised so that all aspects of the appeal must be retained by the Board until the factual issues are decided. Consequently, the Board denies the request for EJR.

See Letter of November 8, 1991 from Jack Martin, Chairman of the PRRB, to Ronald N. Sutter, Plaintiff's Partial Administrative Record at 4. The Board explicitly relied on 42 C.F.R. § 405.1842(g)(2), which permits the Board to decline to make an EJR determination "[i]f there are factual or legal issues in dispute on an issue within the authority of the Board to decide."[9]

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[8] *See* Plaintiffs' Partial Administrative Record at 62-80.

[9] 42 C.F.R. § 405.1842(g) states:

(1) Within 30 days after the date of receipt (as defined in paragraph (i) of this section) of a provider's request and all necessary documentation the Board will issue a determination concerning its authority to decide the question of law, regulations, or HCFA Rulings relevant to the issues identified by the provider in its request.

(2) If there are factual or legal issues in dispute on an issue within the authority of the Board to decide, the Board will not make an expedited review determination on the particular issue but will proceed with a hearing. The Board has the authority to decide when two or more issues are sufficiently related to preclude separation for purposes of an expedited review determination on one or more of them and a hearing on the other or others.

(3) The Board will promptly notify the provider in writing of its

In this case, there is no dispute that the PRRB did *not* determine that it had authority to decide the validity of the Secretary's reaudit regulation. Rather, defendant claims that the PRRB properly followed the regulation interpreting the statute and that the regulation can only be reviewed under the arbitrary and capricious standard.

However, defendant jumps the gun. As noted above, the first step for the court is to determine whether the statute itself speaks to the issue. Statutory interpretation is within the province of the court. *See Chevron*, 467 U.S. at 843 n. 9. It is only when the statute is "silent or ambiguous with respect to the specific issue" that the administrative interpretation controls if it is not arbitrary, capricious, or manifestly contrary to the statute. *See Chevron*, 467 U.S. at 843-44. Here, the statute requires an actual determination of whether or not the PRRB has jurisdiction over the legal or factual questions presented. The fourth sentence indicates that the provider may request a "determination by the Board of its authority to decide the question of law or regulations relevant. . ." The next sentence says that the Board "shall render such determination". This determination refers to the Board's authority to decide. It is mandatory, not discretionary.

The PRRB did not determine whether it had jurisdiction. Consequently, it did not issue a "determination" within the meaning of the 6th sentence of section 1878(f)(1). The Board's 30-day period ended on November 8, 1991. Plaintiffs' suit on January 2, 1992 was within 60 days and therefore timely filed.

Congressional intent supports our interpretation. Defendant's approach would introduce the very problem

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determination and will send a copy of the determination to the intermediary.

(4) The Board's determination concerning its authority or its lack of a determination is not subject of the Secretary's review under § 405.1875.

of delay that Congress sought to avoid with its amendment of the Social Security Act to provide for EJR. The EJR amendments were added to reduce the delay associated with futile appeals to the PRRB, when it did not have authority to determine the validity of the regulation or law. The House Report accompanying the statute, for example, decried the previous system because it required the provider to first bring a complaint about a regulation to the PRRB,

> even though the Board may not have the authority to reverse or overrule the regulation. (The Board has no authority, for example, to rule on the legality of the Secretary's regulations but it must, nonetheless, conduct a full review of the challenge.) The effect of this process has been to delay the resolution of controversies for extended periods of time and to require providers to pursue a time-consuming and irrelevant administrative review merely to have the right to bring suit in a U.S. District Court. Title VIII addresses this problem by giving medicare providers the right to obtain immediate judicial review in instances where the Board determines that it lacks jurisdiction to grant the relief sought.

H.R. Rep. No. 1167, 96th Cong., 2d Sess. 394 (1980). Defendant would permit the PRRB to refuse to reach a determination of its authority if it believes that there are factual issues within its jurisdiction to decide, and defendant argues that such a determination by the PRRB is unreviewable. It is difficult to see how this would be much of an improvement over that which existed prior to the EJR amendments. The PRRB could still lack the jurisdiction to decide whether the regulation was invalid.

Under the statute, the PRRB may deny an EJR petition filed with respect to a relevant question in a proper appeal only if the Board has the authority to decide an appeal.

The statute does not make EJR discretionary with the Board. The Board must make a determination of whether it has jurisdiction to decide the issue presented; if it does not make such a determination, 42 U.S.C. § 1395oo(f)(1) permits the provider to seek direct judicial review.

In summary, the PRRB failed to make a timely determination of whether it had or did not have jurisdiction over the merits of the dispute as required by 42 U.S.C. § 1395oo(f)(1).[10] We have no difficulty in deciding that we have jurisdiction to review the merits of plaintiffs' claims.

III. The Merits of the Regulation

We next turn to plaintiffs' challenge to the merits of the regulations.

The basis for plaintiffs' claim of invalidity is that the reaudit regulation violates the plain meaning of Section 1886(h)(2)(A) of the Social Security Act. The Act provides:

> The Secretary shall determine for the hospital's cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this title for direct graduate medical education costs of the hospital for each full-time-equivalent resident.

42 U.S.C. § 1395ww(h)(2)(A). Plaintiffs contend that the statute limits the Secretary to the determination of what

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[10] Plaintiffs had also argued in the alternative that the PRRB's decision not to permit EJR was a final decision pursuant to the second sentence of 42 U.S.C. § 1395oo(f)(1). Under such an approach, plaintiffs argued that this Court would still be able to review the EJR determination under the arbitrary and capricious standard. Given our decision that the plain meaning of the statute required a determination of the Board's jurisdiction, we do not reach whether a determination by the PRRB that it has jurisdiction is reviewable as a "final decision" under 42 U.S.C. 1395oo(f)(1). However, we note that the brevity of the decision letter and the Board's lack of jurisdiction to overrule Medicare regulations raises serious doubts about the validity of the Secretary's EJR regulations and the decision in this case.

was previously recognized as reasonable for GME base year costs, and does not permit the use of a different amount. Since the 1984 base year cost report was already final when the regulations were issued in 1989, plaintiffs argue that a reaudit and the concomitant use of different figures would be in contravention of the statute. It is plaintiffs' position that the use of the phrase "shall determine" refers to the amount for each full-time equivalent ("FTE") resident and not to the amount "recognized as reasonable under this title" for direct GME costs. Defendant argues that the regulation says "shall" which provides the Secretary with the discretion to determine what is reasonable and that it is "reasonable" to reaudit to ensure that the claimed GME base period costs were accurate and legitimate. *See* Statement of Points and Authorities in Support of Defendant's Motion for Summary Judgment and in Opposition to Plaintiffs' Motions for Partial Summary Judgment ("Defendant's Mem.") at 17. "Congress' mandate to the Secretary was to make a fresh determination of the per resident amount on the basis of accurate GME costs." *Id.* at 25.

We believe that the plain meaning of the statute does not authorize a reaudit of the 1984 base year costs. We are aided in our analysis by the recent opinion in *Georgetown University Hospital v. Bowen*, 862 F.2d 323 (D.C. Cir. 1988) ("*Georgetown II*"), in which the Court of Appeals construed similar statutory language. In *Georgetown II*, the Court of Appeals had before it a statutory provision of the Medicare Act which instituted the prospective payment system over a four-year phase-in period. During the transition period, Congress directed the Secretary to determine reimbursement levels based in part on a calculation of the hospital's "allowable operating costs of inpatient hospital services" during a particular base year. *See* 862 F.2d at 324 (quoting 42 U.S.C. § 1395ww(b)(3)(A)). The regulations at issue in *Georgetown II* had mandated that when administrative and judicial review required that the

base year figure be adjusted, such a revision would only have prospective effect—the adjustments would only become effective in the phase-in year beginning after the final decision on review. 862 F.2d at 325.

The Court of Appeals found that congressional intent was clear that adjustments to the base year were to have retrospective application as well.

> When Congress chose to incorporate the concept of "allowable" costs into the transitional payment system, it must surely have been aware of the statutory review process for such costs and how such review would inevitably inform the content of any definition of the term "allowable"; we can find no cause to conclude that Congress nevertheless meant to convey some different, more qualified meaning for the term 'allowable' without telling us what it was.

862 F.2d at 326-327 (footnote omitted). The Court noted that Congress had provided for a transition period during which it was clear that Congress meant to keep some of the previous system intact, 862 F.2d at 327, and that Congress also clearly knew how to provide for greater agency discretion when it wanted to do so. *Id.* The Court found that its interpretation was consistent with the available legislative history. 862 F.2d at 328-29.

We think that the Court of Appeals decision in *Georgetown II* is persuasive. Although there are some differences between the two provisions, the principles of interpretation remain the same. The Court in *Georgetown II* interpreted statutory language that was similar to the language at issue in the case at bar. Reimbursement rates were to be based on the allowable costs "recognized under this title for such hospital for the preceding 12-month cost reporting period," 862 F.2d at 326 (quoting 42 U.S.C. § 1395ww(b)(3)(A)), instead of "recognized as reasonable under this title," 42 U.S.C. § 1395ww(h)(2)(A). The Circuit

determined that such costs were those otherwise established through the administrative and judicial review scheme, and that the Secretary's approach of only readjusting the base year and the prospective years from the time of the final decision inappropriately "renders the definition of 'allowable' different for those intermediate years." 862 F.2d at 328. So too in the case at bar.

When Congress included the "average amount recognized as reasonable under this title" as the basis for the FTE resident computation, Congress must have known of the process of review that the provider's figures normally receive. The use of the words "recognized as reasonable under this title" referenced the reasonable cost determination for GME that was in effect in fiscal 1984. If the figures were "recognized as reasonable" for the purpose of determining the costs in fiscal year 1984, they must also be recognized as reasonable for subsequent years. Such figures can not be redetermined at a later date so that there are two different "base-year" amounts being used. Congress could not have intended that the Secretary interpret "recognized as reasonable" to mean two amounts for fiscal 1984: one derived from the standard cost reporting and review process following the close of the fiscal year; and a lower figure recalculated once the Secretary realized that the year would become the base-year for subsequent determinations. Had it wanted a reaudit, Congress was well aware of how to indicate such. The Secretary's failure to use the amount recognized as reasonable for the base year in computing payment under the GME per resident amount violates the plain meaning of the statute.

The conclusion that Congress did not intend to authorize a reaudit follows naturally when looked at within the framework of the provision as a whole. Section 1886(h)(2)(A) is only the first of several paragraphs detailing the "approved FTE resident amount for each cost reporting period beginning on or after July 1, 1985." Subparagraph A specifies fiscal year 1984; the other subpar-

agraphs outline the increases for subsequent years and how hospitals that did not have residency programs in fiscal 1984 should be treated. For example, subparagraph E provides that for hospitals that did not have an approved medical residency training program or were not participating in the program for a cost-reporting period beginning during fiscal 1984,

> the Secretary shall, for the first such period for which it has a such a residency training program and is participating under this title, provide for such approved FTE resident amount as the Secretary determines to be appropriate, based on approved FTE resident amounts for comparable programs.

42 U.S.C. § 1395ww(h)(2)(E). The difference between this clause and the language of (A) is striking—here the amount is an approved FTE as the Secretary determines to be appropriate, whereas in (A) it is the amount "recognized as reasonable". Subparagraph (E), by its terms, gives the Secretary much more discretion. In Section 1886(h)(4)(A), Determination of Full-Time-Equivalent Residents, Congress explicitly gave the Secretary authority to establish rules for the computation of the FTE residents. In contrast, the statute nowhere authorizes the Secretary to establish rules to determine the amount of costs recognized as reasonable. Where Congress chose different language, we must " 'presume that Congress intended the terms to have different meanings.' " *Washington Hospital Center v. Bowen*, 795 F.2d 139, 146 (D.C. Cir. 1986) (quoting *Wilson v. Turnage*, 750 F.2d 1086, 1091 (D.C. Cir. 1984), *vacated on other grounds*, 755 F.2d 967 (D.C. Cir. 1985)).

Additionally, at the time the statute was passed, the base year determinations for fiscal year 1984 were subject to revision. Any concern the Secretary might have had about the accuracy of those figures could have been addressed within the standard three-year period time.

To paraphrase Judge Oberdorfer's opinion in *Georgetown University Hospital v. Bowen*, 698 F. Supp. 290, 296 (D.D.C. 1987), *aff'd*, 862 F.2d 323 (D.C. Cir. 1988), a final determination that a particular cost was reasonable for graduate medical education costs in the base year should provide conclusive proof that the cost should be included in the hospital-specific rate under the GME per resident amount for years subsequent to the base year. There should be no need for a reaudit, and insofar as a reaudit is likely to lead to two different base-year computations, it is impermissible under the statute.

Additional support for this interpretation is provided by the general disfavor of retroactive rulemaking.[11] The Supreme Court has previously stated that an agency is precluded from issuing a retroactive rule absent an "express" statutory grant of power in the statute. *See Bowen v. Georgetown University Hospital*, 488 U.S. 204, 208 (1988) ("*Georgetown I*"). "Even where some substantial justification for retroactive rulemaking is presented, courts should be reluctant to find such authority absent an express statutory grant." 488 U.S. at 208-209. Indeed, in *Georgetown I*, the Supreme Court held that the Medicare Act does not grant general retroactive rulemaking authority to the Secretary, *see* 488 U.S. at 213, and that statutes authorizing the issuance of Medicare rules and regulations "will not be construed to have retroactive effect unless their language requires this result." 488 U.S. at 208.

In the preamble to the GME regulations, the Secretary indicated that he was not "relying on our general grant of rulemaking authority to support retroactive application". 54 Fed. Reg. 40314. Instead, defendant claims that

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[11] "In adjudication, retroactivity is the norm; in legislation it is the exception. In rulemaking, the administrative analogue to legislation, exceptions are fewer still." *Motion Picture Association of America v. Oman*, No. 91-5005, slip op. at 2 (D.C. Cir. July 14, 1992).

the Medicare statute provides the "express" authority for the Secretary to issue GME regulations that have retroactive effect. *See* Defendant's Mem. at 31. Defendant points to an uncodified section of the statute that indicates that the GME amendments are to be effective for "hospital cost periods beginning on or after July 1, 1985" as providing the express authority. Pub. L. No. 99-272, § 9202(b), 100 Stat. 175 (1986). Defendant also notes that several sections of 42 U.S.C. § 1395ww(h) specifically provide that the operative data is for cost periods beginning on or after July 1, 1985, a date which was prior to the enactment of the GME amendments. *See, e.g.*, 42 U.S.C. § 1395ww(h); 42 U.S.C. § 1395ww(h)(2); 42 U.S.C. § 1395ww(h)(2)(C); 42 U.S.C. § 1395ww(h)(3).

Plaintiffs agree with defendant that several provisions in 42 U.S.C. § 1395ww(h) do expressly permit retroactive rulemaking,[12] but argue that such express provision for some items indicates that Congress knew how to permit retroactive rulemaking when it wanted to do so. They argue that the absence of any such explicit direction to retroactively establish GME costs "recognized as reasonable under this title" indicates that Congress did not want to provide retroactive power in this case. Plaintiffs' Memorandum in Opposition to Defendant's Motion for Summary Judgment and in Further Support of Plaintiffs' Motion for Summary Judgment at 24-25. We agree.

While Congress expressly provided the Secretary with some authority to issue rules retroactively, this exception

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[12] Specifically, plaintiffs point to 42 U.S.C. § 1395ww(h)(1) (providing for allocation of GME costs between Medicare trust funds); 42 U.S.C. § 1395ww(h)(2)(E) (providing for an approved FTE resident amounts as the Secretary determines to be appropriate for those programs without an approved residency program in the fiscal year of 1984); 42 U.S.C. § 1395ww(h)(3)(C) (to establish the fraction of the total number of inpatient-bed-days for the Medicare patient load); 42 U.S.C. § 1395ww(h)(5)(F)(ii) (to establish criteria for a geriatric residency or fellowship).

to the general rule of non-retroactivity does not mean that the Secretary may issue *any* retroactive regulations he cares to in implementing the statute. Specifically, the language of the statute weighs against finding retroactive power for the agency to institute new audit requirements. As discussed above, the provision's explicit command to develop rules to compute the FTE residents in 42 U.S.C. 1395ww(h)(4)(A) indicates that Congress considered the need for the Secretary to develop procedures for certain aspects of the GME program; the absence of any such explicit provision for new determinations of reasonable cost gives rise to a strong inference against the Secretary's position. *Cf. Georgetown I*, 488 U.S. at 213-214; *Fedorenko v. United States*, 449 U.S. 490, 512-13 (1981); *Department of Air Force v. Federal Labor Relations Authority*, 877 F.2d 1036, 1041 (D.C. Cir. 1989).

Accordingly, we find that 42 U.S.C. § 1395ww(h)(2)(A) does not permit a reaudit of the base year in order to determine the hospital specific per resident amount for GME costs. The Secretary's regulation constituted an unauthorized retroactive rule. Therefore the Secretary must use the base year costs previously recognized as reasonable for fiscal year 1984 to determine the direct GME costs of the hospital for each FTE resident.[13]

Finally, plaintiffs have moved to compel the production of the opinion of Keith Braganza, a member of the PRRB,

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[13] Plaintiffs also contend that the reaudit regulation is arbitrary and capricious. They base their argument on the fact that the Secretary delayed so long in issuing regulations; that the Secretary directed reaudit of "closed" years—those years that could no longer be reopened under other Medicare principles; that by regulation, hospitals are only required to retain certain records for four years and that the Secretary ordered a reaudit for years for which hospitals were not even required to retain audit records. Plaintiffs also argue that the regulations adopted new and restrictive constructions to be retroactively applied. We do not reach this issue as we find that the language of the statute does not permit a retroactive reaudit of the base year.

dissenting from the Board's EJR determination and for summary judgment with respect to the agency's non-disclosure policy. The PRRB indicated that it was the Board's policy not to release dissents. However, the defendant's response to interrogatories indicated that this "policy" was adopted only nine days before the PRRB decision in this case was issued and after Braganza had discussed his views with the rest of the Board. Indeed, other PRRB dissents have been released and relied upon by district courts.

Plaintiffs argue that the Freedom of Information Act ("FOIA") considers dissents as part of the material that must be released. *See* 5 U.S.C. § 552(a)(2)(A). They argue that the dissents are part of the "record" that must be reviewed by the court. Defendant argues that the dissent is protected by the deliberative process privilege. However, this privilege applies to pre-decisional agency documents, and the dissent in issue is not pre-decisional in nature, as it is adjunct to the PRRB's majority decision to deny the request for EJR. All materials not privileged are discoverable. Fed. R. Civ. P. 26(b)(1). Insofar as there are any remaining issues in these cases, we grant plaintiffs' motion to compel production.

The arguments regarding the legality of the policy not to release dissents revolve around whether the Board's EJR determination is judicially reviewable.[14] As we do not decide whether a PRRB determination to deny EJR is

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[14] Plaintiffs argue that the policy of not releasing dissenting opinions in EJR cases exceeds the Board's rulemaking authority because it is not "necessary or appropriate" to carry out the provisions of Section 1878 of the Act. They argue that the policy violates the judicial review standards of the APA, because it restricts the court in its mandate to conduct a thorough and searching review of whether the decision was based upon a consideration of relevant factors.

In response, defendant argues that the Board's EJR determination are not final decisions, and hence not reviewable. Defendant also argues that requiring dissents to be published would be a waste of resources as the majority opinion would have to be more responsive.

reviewable as a final decision pursuant to 42 U.S.C. § 1395oo(f)(1), we likewise do not reach whether a policy to preclude publication of dissents by a member of the PRRB in an EJR determination is contrary to law. Accordingly, we deny plaintiffs' motion for summary judgment with respect to the PRRB's policy on non-disclosure of dissenting opinions.

In conclusion, we deny defendant's motion to dismiss and defendant's motion for summary judgment. We grant plaintiffs' motion for summary judgment except that we deny plaintiffs' motion for summary judgment with respect to PRRB's policy not to disclose dissenting opinions in EJR determinations. We hold that the Secretary's reaudit regulation, 42 C.F.R. § 413.86(e)(ii), is unlawful as it conflicts with the plain meaning of 42 U.S.C. § 139ww(h)(2)(A) and is an impermissible retroactive rule.

An Order in accordance with the foregoing is entered this day.

/s/ John H. Pratt
JOHN H. PRATT
United States District Judge

Date: 17 July 92

APPENDIX D

United States Court of Appeals
For The District of Columbia Circuit

September Term, 1992
DC CV 92-1120

No. 92-5281

Administrators of the Tulane Educational Fund, doing business as Tulane Medical Center Hospital and Clinic,
Appellees

v.

Louis W. Sullivan, Secretary, Department of Health and Human Services and Consolidated Cases

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United States Court of Appeals
For the District of Columbia Circuit
FILED JUNE 30, 1993
RON GARVIN
CLERK

BEFORE: Wald, Ruth B. Ginsburg and D. H. Ginsburg, Circuit Judges

ORDER

Upon consideration of appellees' petition for rehearing, filed April 23, 1993, it is

ORDERED, by the Court, that the petition is denied.

Per Curiam
FOR THE COURT:
RON GARVIN, CLERK

BY: /s/ Robert A. Bonner
Robert A. Bonner
Deputy Clerk

APPENDIX E

United States Court of Appeals
For The District of Columbia Circuit

September Term, 1992
DC CV 92-1120

No. 92-5281

Administrators of the Tulane Educational Fund, doing business as Tulane Medical Center Hospital and Clinic,
Appellees

v.

Louis W. Sullivan, Secretary, Department of Health and Human Services and Consolidated Cases

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United States Court of Appeals
For the District of Columbia Circuit
FILED JUNE 30, 1993
RON GARVIN
CLERK

BEFORE: Mikva, Chief Judge; Wald, Edwards, Ruth B. Ginsburg, Silberman, Buckley, Williams, D. H. Ginsburg, Sentelle, Henderson, and Randolph, Circuit Judges

ORDER

Appellees' Suggestion For Rehearing *En Banc* has been circulated to the full Court. No member of the Court requested the taking of a vote thereon. Upon consideration of the foregoing it is

ORDERED, by the Court *en banc*, that the suggestion is denied.

Per Curiam
FOR THE COURT:
RON GARVIN, CLERK

BY: /s/ Robert A. Bonner
Robert A. Bonner
Deputy Clerk

APPENDIX F

1. 42 U.S.C. § 1395ww(h) provides in relevant part:

(h) Payments for direct graduate medical education costs

(1) Substitution of special payment rules

Notwithstanding section 1395x(v) of this title, instead of any amounts that are otherwise payable under this subchapter with respect to the reasonable costs of hospitals for direct graduate medical education costs, the Secretary shall provide for payments for such costs in accordance with paragraph (3) of this subsection. In providing for such payments, the Secretary shall provide for an allocation of such payments between part A and part B of this subchapter (and the trust funds established under the respective parts) as reasonably reflects the proportion of direct graduate medical education costs of hospitals associated with the provision of services under each respective part.

(2) Determination of hospital-specific approved FTE resident amounts

The Secretary shall determine, for each hospital with an approved medical residency training program, an approved FTE resident amount for each cost reporting period beginning on or after July 1, 1985, as follows:

(A) Determining allowable average cost per FTE resident in a hospital's base period

The Secretary shall determine, for the hospital's cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this subchapter for direct graduate medical education costs of the hospital for each full-time-equivalent resident.

(B) Updating to the first cost reporting period

(i) In general

The Secretary shall update each average amount determined under subparagraph (A) by the percentage increase in the consumer price index during the 12-month cost reporting period described in such subparagraph.

* * * *

(E) Treatment of certain hospitals

In the case of a hospital that did not have an approved medical residency training program or was not participating in the program under this subchapter for a cost reporting period beginning during fiscal year 1984, the Secretary shall, for the first such period for which it has such a residency training program and is participating under this subchapter, provide for such approved FTE resident amount as the Secretary determines to be appropriate, based on approved FTE resident amounts for comparable programs.

(3) Hospital payment amount per resident

(A) In general

The payment amount, for a hospital cost reporting period beginning on or after July 1, 1985, is equal to the product of—

(i) the aggregate approved amount (as defined in subparagraph (B)) for that period, and

(ii) the hospital's medicare patient load (as defined in subparagraph (C)) for that period.

(B) Aggregate approved amount

As used in subparagraph (A), the term "aggregate approved amount" means, for a hospital cost reporting period, the product of—

(i) the hospital's approved FTE resident amount (determined under paragraph (2)) for that period, and

(ii) the weighted average number of full-time-equivalent residents (as determined under paragraph (4)) in the hospital's approved medical residency training programs in that period.

(C) Medicare patient load

As used in subparagraph (A), the term "medicare patient load" means, with respect to a hospital's cost reporting period, the fraction of the total number of inpatient-bed-days (as established by the Secretary) during the period which are attributable to patients with respect to whom payment may be made under part A of this subchapter.

(4) Determination of full-time-equivalent residents

(A) Rules

The Secretary shall establish rules consistent with this paragraph for the computation of the number of full-time-equivalent residents in an approved medical residency training program.

(B) Adjustment for part-year or part-time residents

Such rules shall take into account individuals who serve as residents for only a portion of a period with a hospital or simultaneously with more than one hospital.

(C) Weighting factors for certain residents

Subject to subparagraph (D), such rules shall provide, in calculating the number of full-time-equivalent residents in an approved residency program—

(i) before July 1, 1986, for each resident the weighting factor is 1.00,

(ii) on or after July 1, 1986, for a resident who is in the resident's initial residency period (as defined in paragraph (5)(F)), the weighting factor is 1.00,

(iii) on or after July 1, 1986, and before July 1, 1987, for a resident who is not in the resident's initial residency period (as defined in paragraph (5)(F)), the weighting factor is .75, and

(iv) on or after July 1, 1987, for a resident who is not in the resident's initial residency period (as defined in paragraph (5)(F)), the weighting factor is .50.

(D) Foreign medical graduates required to pass FMGEMS examination

(i) In general

Except as provided in clause (ii), such rules shall provide that, in the case of an individual who is a foreign medical graduate (as defined in paragraph (5)(D)), the individual shall not be counted as a resident on or after July 1, 1986, unless—

(I) the individual has passed the FMGEMS examination (as defined in paragraph (5)(E)), or

(II) the individual has previously received certification from, or has previously passed the examination of, the Educational Commission for Foreign Medical Graduates.

(ii) Transition for current FMGS

On or after July 1, 1986, but before July 1, 1987, in the case of a foreign medical graduate who—

(I) has served as a resident before July 1, 1986, and is serving as a resident after that date, but

(II) has not passed the FMGEMS examination or a previous examination of the Educational Commission for Foreign Medical Graduates before July 1, 1986,

the individual shall be counted as a resident at a rate equal to one-half of the rate at which the individual would otherwise be counted.

(E) Counting time spent in outpatient settings

Such rules shall provide that only time spent in activities relating to patient care shall be counted and that all the time so spent by a resident under an approved medical residency training program shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital incurs all, or substantially all, of the costs for the training program in that setting.

(5) Definitions and special rules

As used in this subsection:

* * * *

(F) Initial residency period

The term "initial residency period" means the period of board eligibility plus one year, except that—

(i) except as provided in clause (ii), in no case shall the initial period of residency exceed an aggregate period of formal training of more than five years for any individual, and

(ii) a period, of not more than two years, during which an individual is in a geriatric residency

or fellowship program which meets such criteria as the Secretary may establish, shall be treated as part of the initial residency period, but shall not be counted against any limitation on the initial residency period.

The initial residency period shall be determined, with respect to a resident, as of the time the resident enters the residency training program.

* * * *

2. 42 U.S.C. § 1395oo provides in relevant part:

(a) Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board (hereinafter referred to as the "Board") * * * if—

(1) such provider—

(A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such report

* * * *

(f)(1) A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision of the Board, or of any reversal, affirmance, or modification by the Secretary, by a civil action commenced within 60 days of the date on which notice of any final decision by

the Board or of any reversal, affirmance, or modification by the Secretary is received.

* * * *

Such action shall be brought in the district court of the United States for the judicial district in which the provider is located (or, in an action brought jointly by several providers, the judicial district in which the greatest number of such providers are located) or in the District Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of title 5, United States Code, notwithstanding any other provisions in section 205.

3. 42 U.S.C. § 1395ww(a)(1)(C) provides:

The limitation established under subparagraph (A) for any hospital shall in no event be lower than the allowable operating costs of inpatient hospital services (as defined in paragraph (4)) recognized under this subchapter for such hospital for such hospital's last cost reporting period prior to the hospital's first cost reporting period for which this section is in effect.

4. 42 U.S.C. § 1395ww(b)(3)(A) provides:

Except as provided in subparagraphs (C), (D), and (E), for purposes of this subsection, the term "target amount" means, with respect to a hospital for a particular 12-month cost reporting period—

(i) in the case of the first such reporting period for which this subsection is in effect, the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4) of this section) recognized under this subchapter for such hospital for the preceding 12-month cost reporting period, and

(ii) in the case of a later reporting period, the target amount for the preceding 12-month cost reporting period,

increased by the applicable percentage increase under subparagraph (B) for that particular cost reporting period.

5. 42 C.F.R. § 405.481(g) provides in relevant part:

(g) *Recordkeeping requirements.* * * *, each provider that claims payment for services of physicians under this subpart must:

* * * *

(3) Retain each physician compensation allocation, and the information on which it is based, for at least four years after the end of each cost reporting period to which the allocation applies.

6. 42 C.F.R. § 405.1803(a)(1) provides:

Intermediary determination and notice of amount of program reimbursement.

(a) *General requirement.* Upon receipt of a provider's cost report, or amended cost report where permitted or required, the intermediary must within a reasonable period of time (see § 405.1835(b)), furnish the provider and other parties as appropriate (see § 405.1805) a written notice reflecting the intermediary's determination of the total amount of reimbursement due the provider. The intermediary must include the following information in the notice, as appropriate:

(1) *Reasonable cost.* The notice must—

(i) Explain the intermediary's determination of total program reimbursement due the provider on the basis of reasonable cost for the reporting period covered by the cost report or amended cost report; and

(ii) Relate this determination to the provider's claimed total program reimbursement due the provider for this period.

7. 42 C.F.R. § 405.1807 provides:

Effect of intermediary determination.

The determination shall be final and binding on the party or parties to such determination unless:

(a) An intermediary hearing is requested in accordance with § 405.1811 and an intermediary hearing decision rendered in accordance with § 405.1831; or

(b) The intermediary determination is revised in accordance with § 405.1885; or

(c) A Board hearing is requested in accordance with § 405.1835 and a hearing decision rendered pursuant thereto.

8. 42 C.F.R. § 405.1885(a) provides in relevant part:

A determination of an intermediary * * * may be reopened with respect to findings on matters at issue in such determination * * * by such intermediary officer * * * either on motion of such intermediary officer * * * or on the motion of the provider affected by such determination * * * to revise any matter in issue at any such proceedings. * * * any such request to reopen must be made within 3 years of the date of notice of the intermediary determination. No such determination or decision may be reopened after such 3-year period except as provided in paragraphs (d) and (e) of this section.

9. 42 C.F.R. § 413.86(e)(1) provides in relevant part:

Determining per resident amounts for the base period—(1) *For the base period.* (i) Except as provided in paragraph (e)(4) of this section, the intermediary determines a base-period per resident amount for each hospital as follows:

(A) Determine the allowable graduate medical education costs for the cost reporting period beginning on or after October 1, 1983 but before October 1, 1984.

* * * *

(ii) In determining the base-period per resident amount under paragraph (e)(1)(i) of this section, the intermediary—

(A) Verifies the hospital's base-period graduate medical education costs and the hospital's average number of FTE residents;

* * * *

(iii) If the hospital's cost report for its GME base period is no longer subject to reopening under § 405.1885 of this chapter, the intermediary may modify the hospital's base-period costs solely for purposes of computing the per resident amount.